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PROFESSIONAL PRACTICE IN THE NEW NHS:

**A study into the impact of the NHS Reforms on the practice
of doctors and nurses, and the effect on quality of patient care.**

**A thesis submitted to Middlesex University
in partial fulfilment of the requirements for the degree of
Doctor of Philosophy**

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ABSTRACT

PROFESSIONAL PRACTICE IN THE NEW NHS. THE IMPACT OF THE NHS REFORMS ON PROFESSIONAL PRACTICE AND THE EFFECT ON QUALITY OF CARE

This study aims to examine the impact of the NHS Reforms on doctors and nurses in two North London hospitals, in relation to both changes to the nature of professional practice, and the effect on quality of care offered by professionals to their patients. A case study approach is utilised, combining quantitative and qualitative methodologies to explore the consequence of the policy implementation. A survey was carried out to examine the nature and scope of the effects on professional practice, of the NHS Reforms, and to collate examples of improvements and deteriorations in quality of care offered to patients. In-depth interviews were carried out with senior managers in both hospitals and also their purchasing Health Authority, to identify key features of the policy implementation process. In-depth interviews were also carried out with doctors and nurses in both hospitals, working in a range of clinical specialities to explore the experience of professional practice within a changing policy environment. It emerged that there was a shared experience, across both hospitals and professions, of increasing levels of stress, increasing workload and increasing levels of conflict with managers. There is evidence of both improvements and deteriorations in the quality of care offered to patients, but whereas improvements were largely related to the quality element of structure, the deteriorations were closely related to the process element. Analysis of the interview data revealed three distinct responses by professionals to the NHS Reforms, and these related to the differing values and belief systems which were held. Two groups of professionals - the Traditional and the Transformed - have adapted to the changing milieu of the NHS, but the third - the Transitional - have become disenfranchised from the system within which they practice.

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CHAPTER 1

INTRODUCTION TO THE STUDY

A matter of political, professional and public concern

The National Health Service (NHS) has always been a key issue on the political agenda, and a topic of much public debate, and never more so than in the 1990s. Health care reform has been an area of government consideration, not only in Britain, but throughout the world during the last five years, and it is the translation of that consideration into action which has kept the NHS firmly in the public eye.

From the political perspective, concern about the NHS has mainly focused on the escalating cost of services, which was viewed as incompatible with the overall policy aim of reducing public expenditure. Health care professionals have expressed concern about both the overall health status of people in Britain, and the maintenance of professional standards. Public concern about the availability of services, and perceived shortages and inequalities has been the subject of much media interest. Professor Keen (Francome & Marks 1996 p ix) has noted that *'We are clearly very close to a moment of irreversible decision about the future of the NHS.'* What that decision is likely to be will, in large, be determined by how the NHS Reforms of the 1990's are perceived and evaluated, and as yet such evidence remains scanty. This thesis will suggest that the Reforms which were implemented during 1991 have had a number of unintended, and frequently unrecognised consequences, which are likely to have long term effects for patients, health care professionals and the NHS itself.

Rationale and aims of the study

The NHS Reforms can be seen to have presented both health care professionals and managers of health care services, with what is likely to have been the most extreme and extensive set of changes they will have encountered. These Reforms, in setting out to restructure, refocus and reorganise health care funding and provision, had also to accomplish a change in the culture and ethic of health care professionals, and a

remodelling of the traditional power relations within the organisation. It was not only the structure and process of health care provision that was to change, but also the values and beliefs which underpinned the system. Whilst frequently the target of change, in terms of reorganisation, it was generally recognised that the changes of the early 1990s were the most far-reaching, and to an extent, the most unpredictable, for unlike previous changes which were based on an assessment of existing difficulties, and considered planning to overcome those problems identified, these new changes were to be largely based on economic and political theory, previously untested within the field of public health care provision. Implementation was to be enacted without pre-testing, even on a limited scale, and so even the most committed proponents of the reforms could not claim to be able to identify the precise impact that these changes would have, above and beyond the primary aims which were envisaged. Politicians, professionals and managers were embarking on a journey into uncharted territory, and whilst many might have claimed to be able to foresee the eventual destination, none could predict the byroads which would be traversed. It is only by reflecting on the process of change as it is experienced, and by examining a range of the multiplicity of outcomes of change as they become evident that it will be possible to evaluate the impact of the NHS Reforms on the contemporary British health care system. Indeed it may prove to be some considerable time before the full impact of the changes will emerge, as it is likely that such changes will have long term effects on the health care system itself, the professionals who engage in practice within that system, and the patients who seek health care.

Previous evaluative studies of the NHS Reforms of the 1990s have been limited in terms of both number and scope, and whilst government statistics have been utilised to focus on a positive picture of the Reforms in relation to the increase in total number of patients treated, reduction in waiting times and increasingly effective use of limited resources, there has also been a negative focus from the media which has highlighted bed closures, inequalities in access to care and shortages of services. Both positive and negative aspects have been supported by field studies, but empirical evidence remains mixed, inconclusive and unclear (Hughes 1993). Indeed, the ability to evaluate something as large and indeterminate, has been questioned, because even

if the changes can be clearly described, how can value be attributed to such changes? (Cribb 1995).

It can be argued that much of the lack of clarity which can be seen in relation to the attempts to evaluate the NHS Reforms is due to the fact that there has been a failure to address an adequate range of perspectives in this evaluation, in particular the nature of relationship of the health care professional to the patient has been accorded little attention. For patients, whilst of course the structures and outcomes of care are important, the process of care is also a key way in which they will judge health care provision, and for the patient, the essence of the health care services that they receive can be seen to be expressed in the relationship between the health care professional and the patient. The impact of the NHS Reforms on this relationship between professional and patient is an area which has been largely ignored in the area of hospital practice. The centrality of the health care professional/patient relationship can allow this relationship to be the barometer of change in health care services, because whatever the nature of the change it is inevitably reflected at the interface of service delivery, the interaction between health care professional and patient.

Studies which have focused on one aspect of health care provision in relation to the effects of the health care Reforms - the structure and macro-processes of health care (Appleby et al 1994), equity (Whitehead 1994), patient choice (Mahon, Wilkin & Whitehouse 1994) - can only provide a snapshot of the effects of the NHS Reforms. It could be argued that the evaluation of a human service within a complex organisation with multi-factorial influences is severely restricted without a consideration of the human element, for whilst policy decisions are debated at length, both within and outside the political arena, the implementation of policy inevitably rests on those individuals who may have had little input to such debate. In relation to the provision of health care services within the NHS in general, and within NHS hospitals in particular, this human element is best represented by the relationship between the health care professional as the direct provider of care, and the patient, the direct recipient of care, a relationship which of necessity remains central to health care delivery. To examine the effects of policy implementation only in terms of

specific, measurable performance indicators, whilst providing information which is both significant and valuable, displaces the centrality of the human relationship. Such a one dimensional approach lends itself to manipulation of the data, for of what relevance is the length of wait for treatment without a consideration of the process of treatment or of the differing experiences of diverse categories of patients during that period in which they wait for health care intervention? In terms of evaluating the effects of policy changes on the quality of care that is delivered by health care providers, attention needs to be paid to structure, process and outcome (Donabedian 1980). Current hospital performance indicators focus on *structure*, measuring such detail as the organisation of waiting times and length of stay, and the thrust of current research into evidence based care focuses on *outcomes*. The *processes* of care remain largely monitored internally, through the standard setting and audit framework, and thus not widely utilised in terms of policy evaluation.

The aims of this study, therefore, are twofold, firstly to examine the impact of the NHS Reforms on the professional practice of doctors and nurses in the two main provider NHS Hospital Trusts of a North London Health Authority, relating both to the changes to the nature of professional practice, and changes to the quality of care delivered to patients by health care professionals. The second aim of this study is to construct a typology of professional response to the Reforms, with particular reference to the value and belief systems which underpin professional practice. To attempt an evaluation of the health care Reforms requires the determination of whether or not there has been a philosophical shift amongst health care professionals. It is claimed that the NHS is founded on distinct philosophical principles (Caldwell and Francome 1993) and so there needs to be a consideration of this aspect of professional practice in order to fully determine the impact of the policy changes.

Outline of the development of the thesis

Following on from the rationale and aims of the study discussed in this chapter, Chapter 2 will detail the research design and methodology. The key methodological issues and the essential criteria which the study had to meet will be identified, describing how the research was designed, and the basis for the research approach

adopted will be considered. The different methods used for data collection will be outlined, as will the strategies for data analysis and integration. Difficulties which were encountered during the study will be examined, along with the strategies employed to overcome these problems.

Chapter 3 explores the background to NHS care in Britain, discussing how the health care system which pre-dated the NHS came to be viewed as problematic, and examining how the foundations for the NHS were laid. The way in which the vision of a nationalised health care system came to be translated into a reality will be explored, highlighting the roles of both the politicians and the professional bodies. An overview will be given of the first thirty years of the NHS in Britain.

In Chapter 4, the development of a challenge to the NHS will be analysed, examining political, ideological and economic influences, and tracing the policy developments during the last twenty years. The role of the growth in managerialism, and the strengthening ideology of the New Right in paving the road to health care reform will be explored.

Chapter 5 examines in detail the proposals for reform presented in 'Working for Patients' (1989a). The philosophy underpinning the proposals is examined, as is the response to the proposals from the politicians, the professionals and the public. The implementation of the proposals contained in the White Paper is outlined, and evidence of the effects of this implementation is assessed.

In Chapter 6 the focus is on quality of care, outlining philosophical, political and practical perspectives. The issue of quality in the NHS is discussed, and the strategies for quality assurance which have been utilised are examined. Factors which have been highlighted as influences on quality of patient care are explored, and the impact of the NHS Reforms on such care is analysed.

Chapter 7 presents the findings of the study in relation to the nature and scope of the impact of the Reforms on professional practice. Data collected from interviews with

managers and professionals is analysed to explore the way in which the NHS Reforms were implemented in the two hospitals are compared, and similarities and differences are identified. Reflections of managers and professionals on the success of the reforms are considered. A survey of professionals is utilised to examine changes in workload and levels of conflict and stress are detailed and related to profession, place of work and area of clinical speciality.

In Chapter 8 the changing nature of professional practice since the implementation of the NHS Reforms is investigated, again utilising interview and survey data from doctors and nurses. A number of specific ways in which the NHS Reforms have created a change in professional practice are identified, and similarities and differences are highlighted between hospitals, professions and area of clinical speciality.

Chapter 9 explores the impact of the NHS Reforms in relation to the quality of care delivered by doctors and nurses to their patients. Overall changes are discussed, and examples of both improvements and deteriorations in the quality of care obtained from the survey are used to analyse both the level and the nature of this change. Differences existing between hospital, profession and area of clinical speciality are identified, and explored through analysis of the interview data. Differences between the nature of improvements and deteriorations will be demonstrated, using a matrix constructed from two accepted quality frameworks.

In Chapter 10 the existence of a change in the value and belief system which underpins professional practice is demonstrated, and used to construct a typology of professional response to the NHS Reforms. Three distinct models are identified. Traditional professionals, who rather than changing their beliefs, had consolidated and strengthened their commitment to a system which views health care as a social right, as a result of their experience of the implementation of the Reforms. Transformed professionals, on the other hand, appeared to have moved their beliefs towards a stronger commitment to a health care system which views health care as a service commodity. Transitional professionals shared some of the beliefs of the other two

groups, and experienced some conflict in their assumptions about what a health care system should value. Characteristics of each type of professional are examined in relation to a variety of criteria emerging from an analysis of the interview data.

Finally, in Chapter 11, the major findings of this study are highlighted, and discussed. The possible long term effects of the changes which have been demonstrated are suggested, and areas for further study are identified.

CHAPTER 2

METHODOLOGY OF THE STUDY

Methodological issues

The evaluation of health and welfare policy, whether on a large or a small scale, can never be anything other than problematic and complex. In terms of evaluating the impact of the NHS Reforms, no matter how the research question is formulated, there remain several important methodological issues:

- (1) The NHS Reforms, whilst subject to staged implementation were, as previously mentioned, implemented without any form of pre-testing, controls or pilot studies, and so comparative studies have not been possible. The options for evaluating the impact of the Reforms, therefore, is limited to either the monitoring of change over time, or the comparison of actual with predicted outcome (Appleby et al 1994).
- (2) It is not possible to control for all the social, political and professional changes which were happening alongside the implementation of the Reforms, and so isolating the effects of the Reforms is extremely difficult. These changes include increasing awareness of the demographic changes impacting on the health care system, and a transformation in the process of nurse education, among others.
- (3) The time available to complete an evaluative study of the NHS Reforms is limited, for it is recognised that, as full implementation is achieved, so the system will become accepted as the status quo, and professionals will have increasing difficulty in identifying the changes in their practice which can be directly related to the NHS Reforms, rather than to any other co-existing change. The fieldwork, therefore, was scheduled to be carried out between 1992 and 1994.
- (4) It must also be acknowledged that the NHS was, at the time of the implementation of the policies outlined in the 'Working for Patients' White Paper (DoH 1989a), already the subject of changes which either

pre-dated or were unrelated to the Reforms under consideration. Such changes included developments in health care practice and technology, waiting list initiatives and continued expansion of the model of general management.

These methodological limitations, along with the theoretical framework within which the research developed, were the key influences on the research design and planning.

Research design

The design of this study had to fulfil a number of essential criteria above and beyond the central research question:

- (1) It had to be acceptable to both professionals and managers, in order for access to be ensured.
- (2) It needed to be flexible in terms of the schedule of fieldwork, for the NHS is a dynamic organisation and would inevitably undergo change and development during the period of the study which would impact on the availability of health care professionals to be involved in the study.
- (3) It had to take account of the demands of the environment in which professionals engage in practice, and not impinge unduly on the time available for doctors and nurses to spend with their patients. It also had to take account of the possible repercussions of the issues which arose during the course of the study.
- (4) It required a sensitive balance to be obtained in relation to the breadth and depth of the data which would be collected and subsequently analysed, in order for the central research question to be considered in the social, political and professional context within which it exists.
- (5) It had to recognise the scope and limitations of a study of this nature, which would be viable, especially in relation to the time frame.

A case study approach was elected to allow the depth of the research question to be explored, yet would also provide achievable limitations to the quantity of data which would be collected and subsequently analysed. A range of research strategies were

adopted in the formulation of the research design, all of which had clearly identified aims:

- (1) A Delphi study was chosen to formulate a structure for the survey (Linstone and Turoff 1975).
- (2) A survey of doctors and nurses within the two chosen NHS Hospital Trusts aimed to examine three main areas:
 - (a) The extent of the effects of the NHS Reform.
 - (b) The identification of any changes occurring in professional practice as a direct result of the NHS Reforms.
 - (c) The identification of any changes in the quality of care delivered by professionals as a direct result of the NHS Reforms.
- (3) A review of the contemporary as well as the historical documents which related to the establishment of the NHS, and changes over the years, would allow the present changes to be seen in their historical context.
- (4) Interviews with key personnel in the Health Authority and the two hospitals who had been involved in the implementation of the Reforms aimed to both describe the process of implementation and to reveal any differences in the way in which the reforms were implemented in the two hospitals
- (5) Interviews with doctors and nurses in the two hospitals were used to expand and attempt to explain the issues which had emerged from the survey, and also to explore the professional experience of the implementation of the NHS Reforms. The value and belief systems which underpin professional practice were also examined during the interviews, and evidence sought as to whether those values had undergone any change during the time in which the NHS Reforms were implemented.

Rationale for chosen research approach

Despite the difficulties inherent in such an approach, a combined quantitative and qualitative strategy appeared to offer the greatest scope for acquiring both breadth and depth of data, and thus opening up the possibilities for enriching the analysis both in terms of insight into what can often be seen as the closed world of professional practice, and comprehension of the complexity of organisational and policy influences on both health care professionals and patients. The use of a combined methodological approach has been argued to provide several general advantages in a number of academic disciplines:

- (1) Such an approach can be seen to increase the comprehensiveness of the phenomenon being explored (Goodwin and Goodwin 1984).
- (2) Combinations of different methodological approaches allow increased flexibility in the exploration of dynamic phenomenon, which may undergo change during the period of study (Huck, Cormier and Bounds 1974).
- (3) Combining a qualitative with a quantitative approach enables multi-purpose research to be tackled in the most efficient and effective way (Reichardt and Cook 1979).
- (4) Utilising qualitative and quantitative methodologies in the same study allows data which is relevant to different types of questions to be explored (Silverman 1985).
- (5) Data obtained from the two different approaches can be used for purposes of cross validation (Goodwin and Goodwin 1984).

The value of both quantitative and qualitative data is recognised in the research design, as are the limitations of both a single paradigm approach and a combined approach. Quantitative data, whilst providing valuable information as to the nature, location and extent of the impact of the NHS Reforms on professional practice, and the relation of this impact to the quality of care delivered by health care professionals to patients, is limited in the degree to which it can provide insights and explanations. In recent years it has become generally accepted that qualitative research does have a significant role to play in applied policy research:

What qualitative research can offer the policy maker is a theory of social action grounded on the experiences - the world view - of those likely to be affected by a policy decision or thought to be part of the problem. (Walker 1985 p 19)

There is no reason why those techniques which provide valuable insight to the policy maker cannot also be utilised by those who are engaging in the evaluation of policy implementation. Having already identified that it is the human element which is so far lacking in the attempts to evaluate the impact of the implementation of the NHS reforms, then the adoption of a qualitative approach afforded most scope for exploring that element. The benefits of incorporating a qualitative aspect to policy focused research has been well articulated:

The last two decades have seen a notable growth in the use of qualitative methods for applied social policy research. Qualitative research is now used to explore and understand a diversity of social and public policy issues, either as an independent research strategy or in combination with some form of statistical inquiry. The wider use of qualitative methods has come about for a number of reasons but is underpinned by the persistent requirement in social policy fields to understand complex behaviours, needs, systems and cultures. (Ritchie and Spencer 1994 p 173)

The role of a qualitative approach in the study of the impact of the implementation of the NHS Reforms, and in particular to the exploration of the experiences of the health care professionals involved in these changes, can be seen to be compatible with the primary role of qualitative research in general:

The most fundamental characteristic of qualitative research is that it expresses commitment to viewing events, action, norms, values etc. from the perspective of the people who are being studied.....The strategy of taking the subject's perspective is often expressed in terms of seeing through the eyes of the people you are studying....involves a preparedness to empathize (though not necessarily to sympathize) with those being studied...entails a capacity to penetrate the frames of meaning with which they operate. (Bryman 1988 p 61)

Whilst much of the literature relating to the combination of quantitative and qualitative approaches to research have focused on the benefits of triangulation (Denzin 1978, Jick 1979), others have suggested alternative, specific, reasons for choosing such an approach (Greene, Caracelli and Graham 1979, Mathison 1988). The benefits for a combined approach for this study can be seen to be most evident in three main areas:

- (1) Data collection was developmental in itself, in that the qualitative data was used to formulate the framework for collecting the quantitative data, and conversely the quantitative data allowed the 'mapping out' of the issues to be addressed during further qualitative stages of the study. The quantitative data was further explored through the use of a qualitative approach which allowed the analysis of the quantitative data to be enhanced. This approach could be seen to enhance the flexibility which was identified as being required of such a study.
- (2) The data collected, utilising the combined method, was interrelated and so could highlight different facets of the phenomena under study, and also allowed the identification of any overarching aspects which existed. It also provided the opportunity to extend the data collection in areas where deficiencies became evident.
- (3) The breadth and scope of the study was extended beyond that which could have been achieved by adherence to an approach of a single paradigm, and thus went some way to overcome some of the dilemmas previously discussed as being associated with evaluative studies of this nature.

So whilst a model of research design based on a single paradigm was seen to be inappropriate, the combined approach did appear to meet the essential criteria identified for the study, and a range of research methodologies could be seen to be suitable for data collection. The problems which can be associated with such a combined approach have been identified (Mason 1993), and were considered at all stages of the study:

- (1) Quantitative and qualitative data cannot merely be combined, and the

relationships between the data collected needed to be clearly identified and articulated, otherwise the analysis would have been fragmented and lacking in clarity.

- (2) The possibility existed that different methods of data collection could have provided contradictory data, which could have contradicted the validity of either or both approaches.
- (3) Analysis of the data needed to take account of the context of the data collection method.

During the process of data analysis, the method of integrating quantitative and qualitative data needed to be consistent, and the challenges of integrating data in this way have been well articulated:

The challenge of integrating these two data sets involved two elements. First it involved dealing with the intellectual questions.....The second element involved dealing with the more technical questions about how to actually do the integrating, that is how to 'glue together' data which has been produced by methods with different logical principles. This could only really be accomplished after the first element, the intellectual questions had been worked through. (Mason 1994 p 105)

Several strategies for data integration evolved during the study and were adopted during data analysis:

- (1) Key areas, such as changing professional practice and quality of care, were explored using more than one methodology, and the data sets were examined both separately and together, and the qualitative data set was utilised to provide, in many cases, an explanatory framework for the quantitative data set.
- (2) Issues emerging as significant during the survey were followed up during the interviews, and as the focus of critical incident analyses, so whereas the quantitative data set could be seen to provide breadth of data, the qualitative data set could be seen to provide the depth.
- (3) Presenting the data sets alongside each other allowed the identification of relationships between the quantitative and qualitative data sets.

Although there has been a tradition to consider qualitative and quantitative research as distinct and discrete paradigms, it can also be argued that to create such a distinction is to do no more than to create 'ideal types' against which reality can be judged, such approaches are perhaps best addressed by considering them as a continuum of research activity, with relatively few of such activities meeting the criteria of the ideal type of either qualitative or quantitative research:

The tendency to talk about quantitative and qualitative research as though they are separate paradigms has produced ideal-type descriptions of each tradition with strong programmatic overtones, and consequently has obscured the areas of overlap, both actual and potential between them. (Bryman 1988 p 173)

Case study

A case study approach was adopted, focusing on two NHS Hospital Trusts who were the major providers for a North London Health Authority. These two hospitals provided an extensive range of health care services for a large North London area. Permission for access to carry out the study was sought and obtained from the Chief Executives of the hospitals, and also from the Chairman of the Health Authority. Clearance from the local ethics committee was also obtained. Pseudonyms have been used throughout to maintain confidentiality.

The two hospitals in this study are both designated acute general hospitals of comparable size in terms of bed availability, staff, and patient throughput. They both provide a full range of accident and emergency, orthopaedic, general medical and surgical, and general paediatric services. In addition both hospitals provide some specialist services within both the medical and surgical area. The two hospitals share many of the same structural problems, having a mix of buildings from the turn of the century, and more recent additions over the last thirty years resulting in a rather disjointed formation, not best suited for the needs of a modern health care provider. Although geographically close and both situated within the same Local Authority area, each hospital is the main provider for different Local Authority areas and serves a very different population. Greenfield is situated on the border of a green belt area, in an affluent area of the borough serving a largely homogenous population. The

minority ethnic groups resident in this borough are amongst the more affluent of such groups, and are active both within the community and in local politics. Whilst the borough contains pockets of deprivation, on the whole it fares well across a range of social indicators. There are two private hospitals situated within a mile of Greenfield, and a thriving private community services sector. A very small minority of patients attending Greenfield are not registered with a local GP.

Stockton, on the other hand, situated on the opposite border of the borough, mainly serves the population of the adjoining borough which is much more socially and culturally diverse. This area is one of relative deprivation, the population faring poorly across a wide range of social indicators. A high proportion of the population of this borough are members of more disadvantaged minority ethnic groups, and whilst great progress has been made at community level to integrate these groups into the community, divisions are still evident. Within this area there is little take-up of private health care, and a much larger minority of patients attending Stockton are not registered with a local GP than is the case at Greenfield.

The cultures of the two hospitals also differ. Greenfield demonstrates an open culture which supports the expression of honest opinion from the professional staff. There is a recognition when differences exist. Alternative perspectives are discussed frankly between those involved, and although opposition from the professional staff may not always succeed in its aims, they are heard at all levels of the organisation. This has resulted in an organisation in which all staff articulate their concerns openly and coherently. In Stockton however, there is a different culture, which supports less open discussion of problems and differences. A much higher level of discussion goes on 'behind closed doors'. Staff have not developed such a level of debate as have their colleagues at Greenfield. This has led to some problems, as a number of differences between professional staff and managers have escalated markedly, resulting in one instance in the Consultants issuing a vote of no confidence against the Chief Executive. Such a history has led to the development of an atmosphere of some distrust which has further impeded open discussion.

The use of a case study approach can be seen to have had several advantages:

- (1) Whilst geographically close the two hospitals cater for a very different client group, one being situated in a green belt location in a relatively affluent area, serving a largely homogenous population, the other situated in a relatively deprived area, serving a much more culturally and socially diverse population. There also appeared to have been differences in the ways in which the NHS Reforms had been implemented within the two hospitals. Thus the contextual limitations of such a study was, to a degree, curtailed, by a comparison of the two hospitals.
- (2) The researcher having both professional and educational links with the two hospitals facilitated a level of access to both the organisation and the professionals working within it, which would have been extremely difficult to obtain without some level of insider acceptance. Gaining entry through the organisations 'gatekeepers' can be problematic in this type of research (Marshall and Rossman 1989), and so, whilst such a study requires external objectivity, acceptance was a key issue. Professional practice often remains a 'closed world' to those outside the profession, what has been referred to as the 'secret garden':

The 'secret garden' is the private world of professionals, which is unknown, untouched and unaccountable to ordinary people.
(Spiers 1995 p X11)

Therefore credibility of both the study and the researcher was essential because it was recognized that several sensitive issues existed:

- (a) The structure of the Reforms is such that the two hospitals are, essentially, in competition with each other in terms of the contracting process, and so the acknowledgement of the confidentiality of business information was of paramount importance
- (b) Issues which were explored in relation to the quality of care had both professional and personal implications for the practitioners, and if such issues were to be

explored in adequate depth, a trusting relationship between researcher and professional needed to be established.

- (c) Reliance on the certainty that the researcher was also bound by a professional Code of Conduct did, to a large degree overcome the problem of gaining access to the 'closed world' of professional practice
 - (d) The implementation of the NHS Reforms had transformed relationships within the NHS, and as a result of this transformation it was possible that the health care professionals studied might have feared that in revealing information, they were threatening their role within the organisation.
- (3) Whilst it would have been possible to obtain a greater quantity of data if the study extended across Health Authorities, or included a larger number of hospitals, this could only be achieved at the expense of the depth of data which was available. For the purpose of this study a case study approach allowed a greater range of methodologies to be utilised, which allowed the enhancement of both understanding and explanation.

Having outlined the advantages of adopting the case study strategy, the limitations were also recognised:

- (1) It was accepted that it may not have been possible to identify whether any of the variables made these two hospitals unique, and thus the findings would not necessarily be generalisable across the NHS.
- (2) It was recognised that the use of a case study approach could have been viewed by the respondents as lacking in anonymity, and thus potentially could have limited the information that they were prepared to share.
- (3) The field work for this study needed to be completed within a fairly narrow time frame, for reasons previously detailed. Thus steps had to

be taken to avoid impinging too greatly on professional time in any one area of practice.

Identifying the key players in the implementation process was aided by perusal of the public documents, and the main difficulty was seen to be that a significant number of these key players were found to have obtained new posts and/or have moved out of the area. However, initial approaches suggested that there were still individuals in post who had an in-depth knowledge of the ways in which implementation had been achieved in both of the hospitals. For the purposes of this study interviews were carried out with two senior managers from each hospital, and two Health Authority Officers. The data from these interviews was subsequently used to describe, compare and contrast the ways in which the NHS Reforms were implemented in the two hospitals. The managers' perceptions of the implementation process were also compared with the perceptions of the health care professionals.

Delphi study

The wide range of reported perceptions of the effects of the NHS Reforms on the professional practice of doctors and nurses is, like much of the evidence relating to the impact of the Reforms, mixed and unclear. In order to impose some structure and clarity on the range of effects which would be subject to detailed study, a Delphi study was carried out, the aim of which was for a group of experts to reach a consensus decision as to the most significant effects of the NHS Reforms. The Delphi technique (Linstone and Turoff 1975) is a technique which can be utilised to incorporate professional judgement into research instruments, and has been successfully utilised in a number of health care research studies (Reid and Boore 1987). Introduced in California by the RAND corporation, the development of the Delphi technique was an attempt to curtail interpersonal interaction as the controlling variable in group decision making. Four key characteristics which distinguish this technique from other group decision making processes have been identified (Goodman 1987) - anonymity, reiteration with controlled feedback, statistical group response and expert input.

Several distinct stages to this technique were carried out:

- (1) Stage 1 - the researcher established a simple structure to the problem, which took the form of a list of possible effects of the NHS Reforms, which was derived from a review of the professional journals.
- (2) Stage 2 - a Delphi panel was assembled, which consisted of four doctors and four nurses, from outside of the area in which the main study was to take place.
- (3) Stage 3 - the list of the effects of the NHS Reforms which had been formulated in Stage 1 was circulated, by post, to the panel, along with instructions to:
 - (a) Add any items considered important.
 - (b) Delete any items considered unimportant.
 - (c) Give a weighting to each item from 1 to 10, 1 being of low importance, and 10 being of significant importance.
- (4) Stage 4 - the items on which there was no consensus were identified, and returned to the panel along with a summary of the range of opinions expressed, and the instruction to reconsider the item and respond as before. This stage was repeated until complete consensus was achieved, and after two rounds the four key effects of the NHS Reforms on professionals were identified. The areas which had been viewed as significant in relation to the effect of the Reforms on professional practice were, firstly, workload, both in terms of level and balance, secondly, conflict with management, thirdly, experience of stress, and finally, changes in the nature, structure and organisation of professional practice.
- (5) Stage 5 - the items about which there was consensus that they were of significant importance were included in the questionnaire to be used to collect survey data.

Survey

The purpose of the survey was twofold. First it set out to examine the level of the effects of the NHS Reforms on professional practice as had been identified by the

Delphi study and secondly it aimed to identify both specific changes in practice which have occurred and changes to the quality of care delivered by health care professionals to patients. The advantages of using a survey for this data collection included:

- (1) It allowed a detailed description of the extent of the impact of the NHS Reforms on professional practice in relation to the key areas identified by the Delphi study.
- (2) A large amount of data was accumulated, and in relation to the level of effects of the NHS Reforms, this was structured in a way that allowed regression analysis to identify the significance of a range of variables.
- (3) The questionnaire was designed to include open questions to allow respondents to identify ways in which their professional practice had changed as a result of the Reforms, and also to provide examples of improvements and deteriorations in the quality of care delivered to patients.
- (4) Anonymity of respondents overcame, to some extent, the potential difficulties of acquiring data of a sensitive nature.
- (5) Surveys, whilst not always providing results that can be applied universally, do have a role in the identification of shared attributes (Babbie 1990). Whilst no claims will be made that the results of this study can be used to generalise to all practitioners in every field of practice, it was able to identify common attributes between medicine and nursing, and also between clinical specialities.

The survey which was carried out in the early stages of the study was cross-sectional. A postal questionnaire was used to survey hospital consultants and senior clinical nurses. Whilst 100% of consultants were studied, just 70% of nurses were respondents in order to avoid too extensive an effect on clinical workload. The nurses studied were selected by a process of proportionate stratification in relation to both place of work and clinical speciality. By ensuring that the correct proportion for each stratum was selected the sampling errors for the survey variables could be reduced (Hughes 1978). Omitted from the sample were those who had joint

appointments in both hospitals and those who worked less than 0.4 whole time equivalent (WTE) as it was possible that the results would not only reflect the professional practice within one hospital in the case study area. The first mailing was carried out in mid May, and the second in mid June, which aimed to avoid the most popular holiday periods, yet was not at a time when workload was likely to be unusually high, which may have reduced the response rate. Following the second mailing reminders to respond were posted onto notice boards.

The instrument used for the collection of survey data was designed utilising the results of the Delphi study to ensure content validity, and was subject to a small pilot study of 10 doctors and 10 nurses working outside the area of study. This pilot was subject to test and re-test in a six week period, and the reliability of the data collection instrument was thus ascertained, and the r^2 value was found to be 0.79 which indicates good test re-test reliability (Fink 1995). For the first purpose of the survey, to establish the level of impact of the NHS Reforms on health care professionals, a Likert scale was used to determine the professionals judgement of the level of impact on their own practice in relation to the previous key impacts identified. For the second purpose of the survey an open question was posed, requesting examples of ways in which professional practice had changed. For the third purpose of the survey a closed question was asked requesting an overall evaluation of the effects of the NHS Reforms on the quality of care offered, and then two open ended questions requested examples of ways in which the quality of care had improved and/or deteriorated. Each respondent was also asked details of place of work, profession, clinical work area, length of service in the NHS, and length of service in current post.

Data obtained from the survey was coded and then loaded onto Minitab. Profiles of respondents between hospitals, between professions and between clinical work areas, allowed comparison of responses. The open questions were coded and subject to regression analysis. The significance of differences between hospitals, professions and area of clinical speciality was determined by dividing each of the two samples into two categories determined by the value of the second variable and constructing a 2

x 2 contingency table. This involves collapsing the clinical speciality categories. A simple *Chi*-square calculation was then carried out using Yates' correction. A matrix framework was constructed utilising the components of quality identified by Maxwell (1984) - access, equity, acceptability, efficiency, effectiveness and appropriateness, and the elements of quality identified by Donabedian (1980) - structure, process and outcome. This framework was utilised to panel code the examples provided by the survey respondents, in order to obtain a mapping out of the areas of changing quality of care. The use of a panel to code the answers from the open ended questions was adopted in an attempt to minimise researcher bias from this stage of the data analysis. Confidentiality of the survey data was maintained by extracting the data utilised for panel coding from the completed questionnaires. In addition the comments from respondents provided material for qualitative analysis, and were used as a framework for the interviews with professionals.

Depth interviews

Two categories of interviews were undertaken during this study, the first category was the depth interviews with key players in the implementation process, which have already been outlined in the case study section. The second category, again using depth interviews, was to explore the experience of health care professionals in relation to the implementation of the NHS Reforms, and the ways in which such experiences have shaped the nature of their professional practice:

The truth value of a qualitative investigation generally resides in the discovery of human phenomena or experiences as they are lived or perceived by subjects, rather than in the verification of a priori conceptions of those experiences. Significantly truth is subject-oriented rather than researcher-defined. (Sandelowski 1986 p 27)

This research framework which can be seen to advance reflection on practice experience can be seen to be one of a range of qualitative research designs (Tesch 1990), but one which can be seen to be particularly suited to health care professionals, reflection being a familiar component of their everyday practice (Schon 1983).

Prior to undertaking the interviews in the case study area, two pilot interviews were carried out with health care professionals outside of the case study area. This allowed the researcher to estimate the time which should be allowed for each interview, to construct an interview schedule and also to develop an interview guide which could act as a cue for the case study interviews. Once this had been completed requests were made for interviews to doctors and nurses working in a range of clinical specialities at both hospitals within the case study area. The number of interviews carried out was not pre-determined and at completion of the field work 21 interviews had been carried out, 11 at Greenfield, and 10 at Stockton. Of those interviewed 9 were doctors and 12 nurses, 5 worked in Medical areas, 5 in surgical, 3 in trauma/orthopaedic, 2 in intensive care, 2 in theatre/anaesthetics, 3 in paediatrics and 1 in radiology (categorised as other clinical areas in the survey). All of the interviews carried out were recorded and later transcribed, permission having first been sought from the interviewee. Field notes were also made during the interviews, again with the permission of the interviewee.

Cresswell (1994) has identified the major qualitative paradigm assumptions based on the work of Firestone (1987), Guba and Lincoln (1988) and McCracken (1988), the following being of particular importance for this stage of the study:

- (1) Ontological - reality is both subjective and multiple as viewed by the participants. One of the aims of this study was to explore the experiences of the health care professional in relation to the implementation of the NHS Reforms, and so it is the subjective experience of the individual which is the essence of the enquiry.
- (2) Epistemological - the researcher interacts with that being observed. The interaction between researcher and professional was a major tool of data collection during this study, the researcher exploring with the professional their experiences, and to prompt their reflection on practice situations which could be utilised to illuminate the issue under consideration, using a modified method of critical incident analysis, in which incidents considered significant by the interviewee are explored in order to determine the meaning of the incident in relation to the

study.

- (3) Axiological - the approach is value-laden and biased. It is the values which underpin professional practice, and the changes in those values that may have resulted from implementation of the Reforms, that were examined and used to construct the typology of professional response. Thus data analysis focused on value clarification, and the values of the researcher had to be recognised and distinguished from those of the health care professionals in order to minimise the potential effects of bias in analysis.
- (4) Rhetorical - the language of the research is taken to be informal, based on the personal voice and using accepted qualitative words. For this part of the study the data was structured not only in the personal, but also in the language of the health care professionals, the meaning of which was shared by the researcher. The analysis involved the construction of a typology which used the qualitative language of experience, meaning, values and professionalism.
- (5) Methodological - the process of the research involves an emerging design, patterns and theories developed for understanding, and accuracy and reliability is achieved through verification. The early stages of the study informed the areas to be explored during the interviews, further issues emerged during the early interviews, and were included in latter stage interviews, and the use of such techniques as critical incident analysis (Flanagan 1954) were used when appropriate. As patterns developed it was possible to construct a typology of professional response to the implementation of the NHS Reforms which then allowed real cases to be compared and contrasted with the ideal cases.

For this part of the study the success of the interview was determined by both the quantity and the quality of the data obtained. Three concepts described by Canell and Kahn (1968) as necessary conditions for a successful interview are accessibility, cognition and motivation, and attempts to ensure these three conditions were an

important component of the research design.

Access was requested by letter, detailing the nature of the research, and this was followed up by a telephone call to arrange a meeting. If the researcher was not known to the professional approached, the name of a fellow professional, known to both was offered if the professional wished to 'check out' the credentials of the researcher prior to agreeing to an interview. It was recognised that the two factors which were most likely to improve access were firstly, support for the study by both hospital managers and health care professionals, and secondly credibility of the researcher, as previously discussed.

Cognition, or understanding by the respondent, was strengthened by the inclusion of an outline of the areas to be discussed in the interview, being included in the letter which was sent to confirm the appointment for interview. Prompts also needed to be given on occasion, during the course of the interview, to reiterate its purpose in order to maintain relevancy of the information being obtained.

Motivation for the respondent to provide interview data was largely determined by the initial decision to cooperate, which was influenced by the introductory approach. Both this introduction and the motivation of the respondent to provide accurate information was likely to be influenced by the alleviation of factors which tend to decrease the level of motivation, such as the desire to get on with work, unwillingness to appear unknowledgeable, dislike of the interview content, fear of the consequences and suspicion about the purpose of the study (Moser and Kalton 1971). This was taken into consideration in both the timing and the length of interviews. The workload of health care professionals is not fixed, and so a level of flexibility needed to be built into the planned interview schedule. The aims of the study were reiterated prior to the interview, any questions which arose were answered, and confidentiality of the interview data was assured. The confidentiality issue was addressed in four ways:

- (1) Guarantees were given that information gathered for the purpose of the study would be used only for that purpose and no other.

- (2) Information that would reveal the identity of the interviewee would not be reproduced when the study was written up.
- (3) The recordings of interviews, and the transcripts made would be kept in secure conditions, accessible only to the researcher.
- (4) The interviews with key players in the implementation process were completed prior to the interviews with professionals, so that any fears that interview material may be revealed to the professional's managers could be allayed.

The aims of this stage of the study required that the interview was both open and frank in order that the feelings and experiences of the health care professional could be explored and the values and beliefs which underpinned their professional practice could be identified and clarified. Four ways in which frank discussion can be impeded have been identified (Morton-Williams 1977):

- (1) Interviewees may attempt to rationalise, and seek to put forward only logical reasons for their behaviour, disregarding their feelings and beliefs. To attempt to overcome this potential impediment, attempts were made to personalise the interview, and to focus on the individual's experiences during the implementation of the NHS Reforms, prompts and questions were expressed in language which encouraged free expression. Many of those interviewed, however, had previous experience of reflecting on their professional practice, and so were perhaps more able to focus on feelings and attitudes than individuals, who were not familiar, and comfortable, with a structured process of reflection.
- (2) Interviewees may not be accustomed to putting their feelings into words, and indeed many health care professionals may have been accused of being emotive if they had used the language of feelings, values and beliefs in their discussions about the implementation of the NHS Reforms. In seeking to overcome this barrier the focus of the interview was clearly set out at the beginning, and it was emphasised in prompts and questions, that it was the experience of the individual which was the primary concern of the interview.

- (3) Interviewees may fear being ‘shown up’ and in particular, when discussing their interactions with patients, any degree of ‘professional pride’ may have sought to conceal rather than reveal any deteriorations in the quality of care that the health care professional delivered to the patient. In trying to defeat this barrier to open communication, it was important that rapport was established between the researcher and the interviewee before any sensitive issues were discussed, and so this was an area which was addressed towards the end of the interview, and careful consideration was given to the introduction of the topic of quality of care. A non-judgemental, empathetic approach was found to be most helpful in obtaining information which might have been inconsistent with the health care professionals image of how it should be rather than how it was. The complexities which ensue in relation to the sensitive issues which arise during in-depth interviews, and the range of strategies appropriate for dealing with these complexities cannot be underestimated:

As the techniques of questioning were refined it came to be taken almost for granted that some form of psychoanalytic penetration into the near unconscious was the proper method of handling such affect-laden topics. (Madge 1963 p 534)

It was a common feature of the interviews that feelings and emotions were uncomfortable and intrusive, and this needed to be dealt with both before and during the interview.

- (4) Interviewees may tailor their answers to what they perceive the interviewer wants. Again, the attempt to limit this impediment relied on the purpose of the interview being made clear to the interviewee, and if necessary reiterating the purpose during the interview, as a prompt. It was, of course, important not to enter into social dialogue with the interviewee in an attempt to overcome any resistance to openness, as this would have increased the risk of introducing bias into the interview.

The interviews were analysed using frameworks which were constructed during repeated readings of the transcripts, which facilitated the identification of themes as they emerged. The interview data was then utilized to construct a typology of professional response to the NHS Reforms. The process of the study during this phase can perhaps be best examined by using Turner's (1981) nine sequential stages of theory development, of which the first eight were applicable:

- (1) During the early interviews six main categories of information emerged:
 - (a) The emerging recognition of the values and beliefs which underpin professional practice, and their change over time.
 - (b) The initial, and on-going response to the NHS Reforms.
 - (c) The experience of changing professional practice.
 - (d) The perception of the nature of the experience of the implementation of the NHS Reforms.
 - (e) The nature of the professional relationships with patients and the organisation.
 - (f) The nature of the focus on quality of care.
- (2) Further interviews were carried out until the categories were 'saturated', and confidence in the range and relevance of categories was established.
- (3) Criteria for inclusion in the category were specified, and the categories themselves were more generally defined.
- (4) The general definitions of the categories acted as a guide in the development of the typology which was being constructed.
- (5) Connections were sought between the categories which had been established and other situations in which such categories may be relevant.
- (6) Awareness developed of the relationship of the categories to each other, and to the meaning of the links which were identified.
- (7) Conditions under which the links between categories existed were explored.

- (8) As the theoretical framework of this part of the study was established, so the implications of this in relation to relevant existing theoretical frameworks was considered.

Difficulties encountered during the study

Several problematic issues arose during the study which needed to be addressed, the first being the level of mistrust that there appeared to be among health care professionals. A number of contacts, seventeen in all, were made to the researcher following the first mailing of the questionnaire, to clarify information included in the covering letter, in particular requesting further information about the purpose of the study. For the purpose of the second mailing, a more detailed letter accompanied the questionnaire, which appeared to have met the needs of the respondents more fully, as there were only two further requests for information following the second mailing, both seeking details of the research funding. An awareness of the feelings of uncertainty that the health care professionals were experiencing allowed the researcher to provide additional information and reassurance during the interview stage. Several of the health care professionals interviewed verbalised their fears that the information that they were sharing, could possibly be used to their disadvantage, and needed to be reassured about the confidentiality of the study. It is of course possible that those health care professionals who did not openly raise this issue, may have also felt constrained about the amount of information which was revealed, and so in all interviews reassurance as to confidentiality was offered, even if not sought.

The second difficulty encountered was that there did appear to be a high level of acceptance of the Reforms as resistant to challenge or change, and so to an extent it proved demanding to encourage the health care professionals interviewed to focus on the effects of the implementation of the NHS Reforms, without 'selecting out' that which they perceived as being outside of the area of meaningful exploration because of its inevitability. However, to a degree this difficulty was overcome as trust was established, and the personalised meaning of the experience of the changes was explored. As the interviews progressed it was a frequent occurrence that issues which had been discarded at an early stage of the interview as insignificant re-emerged later

in the interview as something which was meaningful to the individual.

It became evident during the early interviews, that despite the use of pilot interviews to provide a guide for the interview schedule, adequate time had not been allocated for this stage of the study. Several factors can account for this:

- (1) Despite appointments being arranged to suit the health care professionals, there were frequent delays in commencing the interviews, often up to 90 minutes, and on occasion interviews had to be rescheduled, when it was not possible to obtain adequate time for the interview to be carried out. It was not, therefore, feasible to plan to carry out more than one interview in a day, and it proved to be less problematic if appointments were made in the short term rather than the long term.
- (2) Following the interview there was a need for the interviewee to debrief prior to returning to their practice area, which had not been recognised in the planning of the interview schedule. In some instances the time required was limited to a few minutes, in others up to 30 minutes.
- (3) A number of interviews were cancelled at short notice, and had to be re-arranged, and so within a very short space of time the interview schedule had been almost totally disrupted. Despite the difficulties, the health care professionals remained keen to participate, and in most cases the delays were due to circumstances beyond their control.

The time factor became increasingly important as the study progressed, and the interviews which took place towards the latter stage proved to be more difficult to focus solely on the changes created by the implementation of the Reforms, than did the earlier interviews. It became more necessary for the researcher to probe and clarify the nature of the changes which were discussed by the health care professional, and it became evident that as time advanced, so there appeared to be

increasing difficulty in being able to differentiate the changes resulting directly from the Reforms from the changes due to other factors. This required a modification of the interview guide to include more clarification prompts, and a recognition that there would be a point at which the validity of the data would be compromised, and so this stage of the research needed to be compacted into a shorter time span than had originally been planned.

The final problem which was encountered was that of the amount of unsolicited data which was acquired. Many of the health care professionals inadvertently revealed confidential information during the course of the interviews, such information relating to either patient details or management operations. Such data was excluded from the analysis stage for both ethical and professional reasons, although during the interviews it was used to seek clarification of the information being shared. A certain level of unsolicited confidential data was also deliberately, albeit anonymously revealed, which although pertinent to the study could not be used, because to reveal such information could compromise the position of individuals. Such information was securely destroyed by shredding, and the sole use which was made of this material during the analysis was a consideration of the ways and meanings of its acquisition.

In retrospect some of these problems should have been envisaged, and planned for. However the flexibility built into the research design ensured that problems which were encountered could be resolved, and none proved to be insurmountable nor to curtail the acquisition of data.

CHAPTER 3

THE BACKGROUND TO NHS CARE IN BRITAIN

Early systems of health care

Ill health and accidents have always been both accepted as part of the human condition, and feared for their consequences. In contemporary British society the well organised facilities for enabling individuals to cope with the impact and after effects of these misfortunes are so much part of everyday life, that they are often viewed as natural and inevitable components of the lives of those living in Britain, yet such facilities are a relatively recent development in the history of humankind, coming far later than developments in the management of ill health. The first documented evidence of hospitals in Britain appears during the tenth and eleventh century. Prior to this what health care was available remained the province of the family, and in particular the women of the family. In medieval Britain four classes of hospitals can be seen to have been in existence (Carlin 1989), the leper hospital, almshouses, the refuges for travellers provided by monasteries, and those hospitals which were designated to care for the non-leprous sick poor, again most often provided by religious orders. As the church became involved in the provision of health care within the monasteries and refuges, so did the concept of health care leave the private domain to enter the public one. However, it was not until the seventeenth century, with the emergence of the scientific bio-medical approach to ill health, that organised medical care became the main mediating social force in the fight against disease, and the restoration of health.

When hospitals escaped from the stranglehold of organised religious practice around the time of the Renaissance, so they became established around the scientific concepts inherent in the rapidly developing practice of medicine. What was seen to be a powerful and predictive approach to medicine allowed the doctors to develop greater control within society, and to a large extent this shaped the pattern of the development of hospitals for over two hundred years. It could be argued to be one

that remained largely unplanned, and left to the control of a variety of both individuals and organisations whose motivations varied, as did their levels of expertise. The Medical Registration Act of 1858, added to this power by enabling doctors to take control of both medical education and specialist services (Jones 1994). This wholesale adoption of the bio-medical model also had a secondary effect in that it effectively marginalised women from their long held traditional role of caring for the sick and needy, within both the family and the community setting. For, as the medical profession gained status and power, so the role of women became increasingly subordinate, and until the middle of the nineteenth century the nurse was untrained, and the antecedents of the modern nursing profession could be seen to be the domestic servants (Abel-Smith 1968). It was not until the reform of hospital nursing in the latter half of the nineteenth century that training of nurses was introduced, and following the setting up of the Florence Nightingale Training School, nursing gradually came to be viewed as a suitable occupation for gentlewomen, and thus the move towards registration and recognition began along with what was to be the relatively slow progress of the process of professionalisation of nursing (Dingwall, Rafferty and Webster 1988).

In the twentieth century an increasing awareness developed of the necessity for the State to assume a greater level of responsibility for the health and welfare of the people of Britain. For whilst the achievement of significant progress in the field of public health, and legislation to support this area of expanding knowledge had resulted in an improved environment, and therefore improvements in the health status of the population, there was still serious concern over both the level of disease, and the availability of effective health care. Indeed there was generalised surprise, and indeed alarm, at the poor physical condition of many of the men called to fight in the Boer War (1899-1901) which triggered a call for the State to address the issues which had led to this apparently poor standard of health within the sector of society that was, arguably, the most essential for the economical survival and the defence of the country - the working class men of working age (Gilbert 1966).

By 1903 it became obvious that the Conservative government needed to act, as they

came under pressure both within and outside parliament. The situation was one that quite clearly would remain unsatisfactory unless they could reverse the decline in the health of the nation in general, and the working class in particular, which had gradually become apparent alongside the process of industrialisation. The Interdepartmental Committee on Physical Deterioration presented their report (1904) which confirmed the findings of earlier, small-scale social investigations (Rowntree 1901, Booth 1902) that there was widespread malnutrition and disease amongst Britain's working class, which was aligned with serious and widespread poverty, and the issue of whether the government should act, was replaced by how the government should respond to these clearly articulated accounts of the wretched health status of the working class.

At this time health care was variable, in terms of both quality and quantity. Those who could not afford to purchase health care were reliant on that provided by the charitable hospitals, clinics and public dispensaries. Those who were seriously ill, and unable to seek help and advice actively, could, in certain circumstances, be visited at their home by the Medical Officer of the Board of Governors, who was responsible for administering the 1834 Poor Law Amendment Act. However, as this service was only provided on the prevailing principles of both deterrence and economy, such help was often lacking in terms of adequacy and expediency. Those who existed at the higher levels of the social strata were able to avail themselves of the services of those distinguished medical practitioners who were currently in vogue. Although, at this time, there was a growth in both medical and surgical specialities within the University hospitals, the private practice of these specialist doctors was often more in the nature of general practice, as would be recognised today.

Those in society who were neither rich nor destitute usually obtained their medical advice and care from general practitioners for a pre-determined fee. Patients were free to choose any doctor whose fee they could afford, whilst doctors were free to charge their patients what they wished. However, whatever the level of the fee, this was frequently hard to find if the breadwinner was prevented from working and earning to meet his medical bills as well as meeting his everyday expenses. Also,

whilst women were not, on the whole, the main wage-earners, their contribution as a secondary wage-earner, primary homemaker and source of childcare, was often essential for the well-being and survival of the family. Whilst wages were generally low, each family was put in the position of having to weigh up the necessity of medical care with other pressing needs, such as food and shelter, and generally expectations regarding health status were low (Lewis 1984). Particularly amongst the working class, a significant level of ill health was not considered to be outside of the norm, and there was little if any concept of work related disease. Many diseases could be seen to be related to the working conditions which prevailed, with a high incidence of respiratory disorders, and a virtual epidemic of tuberculosis. Women, too, were often fated to be almost continually pregnant or nursing an infant, and were subject to many problems associated with repeated childbirth under conditions of both minimal peri-natal care and poor nutrition, such as anaemia, uterine prolapse and urinary incontinence.

In an attempt to prevent the onset of illness precipitating the onset of destitution, many workers associations started the so-called 'sick clubs', where, for a small weekly payment the worker could draw on the club's funds in time of need. Some general practitioners too, concerned by the health experiences of the working classes, set up 'penny clubs' where (for the payment of a penny a week for each family member), the doctor would agree to supply medical care and treatment. However, these attempts to ensure the provision of health care to the needy working classes, were not universally approved by the medical establishment, and there were several organised attempts to impose a wage limit on those who participated in such schemes in an endeavour to preserve the income of those doctors choosing not to take part in such programmes (Green 1985). Another strategy for increasing the availability of health care services to the poor, which also centred around the concept of self-help, was the development of the self-supporting dispensaries, which were often quite closely linked to the 'medical' or 'penny clubs'. Subscribers to these dispensaries consisted of four types (Hodgkinson 1967) - the donors, the honorary subscribers, the benefitting subscribers and the subscribing parishes - and the main difference between these self-supporting dispensaries and the 'medical' or 'penny clubs' can be

seen to be the input from the parishes to the dispensaries.

Even though those individuals, associations and societies which were responsible for the organisation and administration of these early varieties of sickness assurance were, on the whole, able to hold their own against the opposition of those medical practitioners who were hostile towards them, this did not result in them being able to meet the health care needs of the whole working population, indeed they could often be seen to exclude those who could be said to be in most need, the very poorest, as Hodgkinson (1967) highlights: *'The indigence of the poor proved in some instances an insurmountable barrier.'* The piecemeal provision of health care services which existed in Britain at this time remained a cause for concern amongst those who abhorred the inequalities which could be seen to exist in relation to both health status and access to health care.

Laying the foundations for the NHS

The NHS, whilst often viewed as the product of post World War 2 Britain, can actually be seen to have its foundations constructed much earlier in history.

Health services at public cost were.....of venerable origin, having their source in the mechanisms evolved for poor relief in the sixteenth century .

(Webster 1982 p 2)

However, the earliest legislation which demonstrated the State's growing commitment to the provision of private health care, in addition to public health responsibilities, was the National Insurance Act of 1911 which, is generally recognised as being strongly influenced by the Bismarck reforms in Germany during the 1880's. It was after a visit to Germany in 1908, that David Lloyd George, the Chancellor of the Exchequer and key player of the National Insurance Acts, formulated his plans for a system in Britain which was broadly similar to that which existed in Germany. The impetus for this act can be found in the report of the Royal Commission on the Poor Laws and Relief of Distress which was presented in 1909, and which demanded a rapid response from government. The National Insurance Act provided state funded medical care from General Practitioners for those individuals whose income was below £160 per annum, and also ensured that a certain level of income was

maintained during periods of sickness and unemployment.

Yet despite the obvious importance of this policy development, health care in Britain during the early part of the twentieth century remained an inadequate, partial, patchwork type of provision (Klein 1989), which still failed to ensure minimum provision of medical services to the entire population. It is also apparent that the assumptions regarding the benefits that would accrue from this new system of National Insurance were more aligned to the perceived benefits for the State rather than for the individual, provision being focused on workers rather than any other group.

Profitable from the point of view of productivity.....The workers' physical strength and good will had become important assets. Social insurance became one of the means of investing in human capital. (Rimlinger 1971 pp 9-10)

The acceptance of responsibility for the provision of health care by the State was strongly opposed by the medical establishment, who feared both the financial implications of State control of their working practices, and loss of professional autonomy. This was a finding not reflected in the case of the nursing profession, with whom there was a long history of involvement with state provision of services through the Poor Law establishments (Dean and Bolton 1980, Dingwall, Rafferty and Webster 1988). It could be argued that the role of nurses within the health care system resulted in them having little to lose from any increase in state involvement in health care as it made little if any difference to their working practices whether their employers were private citizens, voluntary organisations or the State. It could also be argued that, as health care became more easily accessible, then demand for such services would increase as more individuals sought health care, having had some of the economic burden relieved, and so more health work would become available, which would improve the possibilities for nurses to access employment opportunities.

To some extent the fears of the medical establishment were only assuaged by both a generous level of payments, and the exclusion of higher income individuals from the scheme (Leathard 1990) which, in effect preserved not only the General Practitioners private practices, but also the inequalities which had existed within the system of

voluntary organisation of sickness insurance schemes. Rather than being administered by the Local Authorities, the National Insurance scheme was controlled by Approved Societies, and there was free choice on the part of doctors as to whether or not they participated in the scheme. Thus medical practitioners were able to retain their professional freedom in the face of the threat of a state controlled system of health care.

The National Insurance Act which was implemented in July 1913 was a radical and significant step towards State involvement in personal as well as public health care, but it was never intended to function as a comprehensive health care system. It took into account not only the health care needs of the population, but also the competing interests of the medical establishment, and therefore was a system which was rendered acceptable enough to all concerned, to become a workable piece of legislation. Because of this history of compromise, which to some extent can be seen to have set a precedent for future negotiations between the State and the medical establishment, and despite the obvious benefits of the National Insurance scheme, it did not overcome all of the problems of the British health care system, in relation to either the availability or the standard of health care. In the period between the First and Second World Wars, the system could be seen to continue to evolve in a rather piecemeal fashion, with subsequent social and geographic variations in both the quantity and quality of health care which was available. From its inception in 1911, and subsequent implementation in 1913, the National Insurance scheme only covered one in three of the population of Britain, and even as late as the 1940's this cover had only been extended to cover half of the population. However, despite its limitations, the 1911 National Insurance Act remains an important landmark in the history of state health care in that it provided a vital part of the policy milieu in which the National Health Service developed (Leichter 1979). Indeed it is difficult to envisage how the development of a nationalised system of health care could have progressed without this intermediate stage, and certainly had it done so, is likely to have emerged in a very different form.

The vision of a nationalised health service

The period between the two World Wars was one during which health care came under increasing pressure, and doubts began to be expressed about the basic viability of the existing system. This could be seen to be a mix, some would argue a mismatch, of primary care provided to a proportion of the population under the National Insurance Act, with a fee-for-service or charitable provision of primary health care for the remaining sector of the population. This was combined with a limited amount of hospital care which was to a large extent provided by voluntary funding, with a much smaller fee-for-service private sector. However, despite the recognition of the difficulties of health care provision during this inter-war period, progress in terms of any fundamental changes, was slow. In an interim report by a committee headed by Lord Dawson and set up by the newly formulated Ministry of Health (Ministry of Health 1920), proposals were presented for what in essence could be seen as a nationalised health service, and it was this report that was to outline the principles and identify the main issues which were to become the focus of discussion for the next thirty years. The model of health care provision suggested in the Dawson report highlighted five key areas for development. First were the domiciliary services which included communal or preventive services such as maternal and child welfare services and school health. Secondly, the primary health centres in which the domiciliary and communal services would be based, and from which general practitioners may choose to work. The third mode of provision, the secondary health centres were basically wider hospital services staffed by consultants and specialists to whom general practitioners could refer patients. Fourthly were those services which were considered as 'supplementary' - that is those requiring separate institutions such as convalescent homes, tuberculosis sanatoria and fever hospitals. Teaching hospitals, it was envisaged would function as centres of excellence for the treatment of those with difficult or highly specialised medical problems, although it was proposed that teaching would also take place in communal services no less than in hospital services. However, despite the comprehensive, farsighted, albeit somewhat radical nature of the Dawson recommendations, the proposals were not implemented as hoped. They were curtailed by the economic and social disruptions during the early 1920's which could be seen to replace the previous post-war

euphoria.

In many ways it could be argued that the story of the evolution of the NHS is in a sense also the story of the long delayed implementation of the Dawson Report (Pater 1981), because, as during previous wars, the experience of World War 2 again focused attention on the problems associated with the health care services in Britain. For, despite the addition of the war-time emergency hospital scheme to the existing voluntary and municipal services, there remained serious shortfalls in the level of services available to both civilians and the armed forces. Throughout the war the Ministry of Health commissioned various regional surveys in order to assemble an overview of health care services throughout the country (Nuffield Provincial Hospitals Trust 1946). These surveys revealed a picture which had largely remained hidden in the patchwork of health care provision of the first half of the twentieth century, clearly demonstrating a shortfall in the required number of beds which was exacerbated by what appeared to be a serious maldistribution of resources. The inequalities which resulted from the inequitable distribution of both material and human resources was evident not only between, but within regions. These problems were seen to be worsened by the disorganised state of both the hospital and the specialist services (Ham 1981). The two different forms of hospital ownership, public and private, were seen to impede the comprehensive planning that was necessary to ensure that the needs of patients could be met effectively. It has been suggested that possibly the most serious fault of the health care system that existed before the NHS was in the seemingly erratic, irrational mode of organisation (Eckstein 1958). The specific drawbacks of the pre-war system of health care have been categorised by Leathard (1990) under five headings:

- (1) The shortages of both facilities and trained manpower.
- (2) The functional and geographical inequalities of service distribution.
- (3) Inefficient use of resources as a direct result of irrational organization.
- (4) Lack of adequate capital funds for service expansion.
- (5) The persistence of several unsatisfactory clinical conditions.

The growing acceptance that there needed to be some form of national health care system in order to overcome the perceived shortcomings of the existing system, was

one which prompted an unprecedented alliance between the British Medical Association (BMA) and the Trades Union Congress (TUC). Although arising, in the first instance, from the issue of the intransigency of the commercial companies which administered the National Health Insurance, in relation to industrial injury compensation claims, this alliance developed into a call for a reconstruction of the nation's health services. The BMA entered into this alliance with the TUC as a result of pressure for reforms from radical groups within the medical profession, especially notable being the Medical Practitioners Union (MPU) and the Socialist Medical Association (SMA). The issue compelling this unlikely and unprecedented alliance was the growing influence of both the MPU and the SMA in relation to the provision of municipal services (Iliffe 1983). Although these unlikely allies did hold compatible aims, their focus was very different, for whilst the TUC highlighted the need for adequate provision of specialist medical attention for the working population, the BMA was more concerned with the belief that quality medical care was reliant upon doctor's autonomy, and that any degree of control from local government was unacceptable. So whilst their beliefs converged on the central idea of a national system of health care, they diverged on their beliefs about the way such a system should be structured and organised.

Thus there developed conflicting views within the medical profession, and indeed within the government, in relation to the structure and organisation of the proposed nationalised health service. Those towards the left of the political spectrum could be seen to be represented by the views of the SMA who had argued for over a decade for municipalization (SMA 1933). Those on the right aligned with the BMA who similarly over recent years had fought vigorously against the loss of autonomy, which they saw as a result of municipalization, and who favoured an extension of the health insurance scheme (BMA 1929; revised 1938).

However, taking into consideration not only the aforementioned reports but also a number of papers issued by various bodies during the inter-war years (Ministry of Health 1920, Royal Commission of National Insurance Service 1928) a convergence of views became apparent on the necessity of devising some form of national health

service as opposed to a national health insurance scheme (Klein 1989).

The creation of the National Health Service

The concerns relating to the provision of health care were closely aligned to those which were being expressed about other areas of welfare such as housing, education, income maintenance and employment. The Second World War added impetus to the development of state involvement in both health and welfare services as a consensus evolved through both an increasing awareness of the concept of citizenship and a decline in the power of the British class system. The Beveridge Report (1942) identified what he termed as the 'five giants' which needed to be overcome during the period of reconstruction - Disease, Ignorance, Squalor, Idleness and Want - all of which he presented proposals for tackling. The means for tackling disease had a particular history which had created its own motivating force; it also needs to be viewed as part of the wider process of social change initiated by Beveridge. As pointed out by Pater (1981) the whole structure of the proposed welfare state could be seen to rest firmly on three assumptions:

- (1) That individual allowances would be paid out of taxation for the support of dependent children.
- (2) That an inclusive health service would be provided, free at the point of delivery, and dissociated from any contributory conditions.
- (3) That policy would be focused towards the maintenance of full employment and the circumvention of mass unemployment.

It was this second assumption which could be seen as the first evidence of the government's commitment to a nationalised health service as opposed to an extension of the national insurance scheme. It can be seen that whilst the Beveridge Report (1942) was concerned with dealing primarily with the principles underpinning the envisioned welfare state especially in relation to income maintenance, it also highlighted the importance of a national system of health services. There were three main reasons why Beveridge viewed the provision of nationalised health care as fundamental to the proposed new welfare system. Firstly, only by enabling people to overcome ill health, could every effort be made to reduce the level of benefits paid

out in terms of sickness benefits. Secondly, it would facilitate early diagnosis and treatment, again reducing expenditure on sickness benefits. Finally, the planned new health service would act as a control agent for the regulation of benefit payments.

Beveridge summed up his call for a nationalised system of health care services thus:

a comprehensive national health service (which) will ensure that for every citizen there is available whatever medical treatment he requires, in whatever form he requires it, domiciliary, institutional, general, specialist or consultant and will ensure also the provision of dental, ophthalmic and surgical appliances, nursing and midwifery and rehabilitation after accidents.....provided where needed without contribution conditions (ie the ability to pay) in any individual case. (Beveridge 1942 Cmnd 6404)

As in many other areas of social policy the nation's experience of war added social momentum to the political plan. Following a draft plan in 1943, the Ministry of Health (1944) issued a White Paper - A National Health Service - the following year. This paper outlined the policy proposals for a comprehensive, universal medical service which would be free at the point of delivery. It has been noted that whilst other countries were, at this time beginning to explore the feasibility of some system of state provision of health care, Britain was the first democracy in the post-war period to go ahead and challenge the medical establishment, and impose a degree of state control over its professional practice (Owen 1988). It was envisaged, at this time, that control of this service would be both central, through Parliament, and local, through the elected local authorities, although it was anticipated that the views of the medical profession would need to be considered carefully, and taken into account in the way in which this service would be structured and organised. Not entirely without surprise, despite the consensus among doctors that a change in the way in which medical services were organised and provided was necessary, the White Paper was faced with much opposition from the medical profession who, it was argued, feared municipalization more than nationalization (Leathard 1990). The BMA engaged in much debate both within the medical profession and with government, and this debate resulted in the publication of the fourteen principles which they believed

should underpin the provision of health care services within Britain (BMA 1943, cited in Pater 1981).

- (1) Reorganisation of medical services must be preceded, or at least accompanied by an improvement in social and environmental conditions.
- (2) Both the quantity and the quality of staff and resources must be guaranteed, medical research should be developed and medical education preserved at a high standard, whilst the economic barriers to medical services should be eliminated.
- (3) The State whilst acting as a coordinator and augmenting resources, must not impinge on the freedom of either the patient or the doctor.
- (4) A salaried service was deemed to be contrary to the public interest, and local authority control was firmly rejected.
- (5) The health service, as any other public service must both preserve and encourage freedom of choice.
- (6) There should be no state intervention in the doctor-patient relationship.
- (7) The concept of freedom of choice should be reinforced by remuneration being related to work done, or patients accepted by the doctor.
- (8) The freedom of the patient to consult the doctor within the health service or privately should be upheld.
- (9) Consultants should be hospital-based, and must retain the right to private practice.
- (10) The structure for central administration should have a medical advisory committee, containing representatives of the profession and free to publish any findings. Locally, representative structures should be set up, including medical advisory committees.
- (11) All areas of medical practice should be viewed as one service, and the schemes proposed for general practitioners should not precede other reforms to the service.
- (12) Whilst awaiting the implementation of the new administrative structures, the National Health Insurance scheme should be extended

to dependents and others of such economic status. Those individuals who were above the income limitations could become voluntary contributors.

- (13) The government and the medical profession should agree to the setting up of experimental schemes in group practices and health centres, and any further development should be based upon the findings of these experiments.
- (14) Whilst a comprehensive health service should be available for all, there was no necessity to provide it for those both willing and able to provide it for themselves.

It finally became the lot of Aneurin Bevan, when he published the National Health Service Bill in 1946, to bear the brunt of the doctor's wrath.

The nursing profession also held some doubts about these proposals for a nationalised system of health care. For, whilst there is no clear evidence to suggest that they opposed the concept itself, they did express disappointment over the lack of any indication of a commitment to any solid role for nurses within the proposed system (Masson 1985). A draft memorandum drawn up by the Royal College of Nursing (1944) framed the outline for discussion at the annual conference later that year. This stressed the need to develop all branches of nursing in relation to the proposed nationalised health service. Further proposals which were supported at this conference included those to expand the home nursing services, to co-ordinate public health and institutional nursing policy and to create health centres with more comprehensive functions than those which had been outlined for the planned group medical practices drafted in the White Paper. It can be seen therefore, that whilst the medical profession, as a body, took a mainly reactive stance in relation to the proposed nationalised health service, the nursing profession, though with less power, adopted a much more pro-active, even visionary approach to state provided health care, (through their professional organisation). In retrospect it could be argued that they held a clearer view as to the possibilities of both benefits and disadvantages of the proposals, which were possibly less clouded by personal economic considerations.

It can be seen that this proposed major change in the mode of delivery of health care services in Britain was, to some extent, stimulated by a similar situation to that which had existed prior to the 1911 National Insurance Act (Leichter 1979). First, there was a growing dissatisfaction with the existing system for the delivery of health care, which was shared by the politicians, the professional providers and the consumers of health care. Secondly, this increasing awareness of the inadequacies of the existing system was exacerbated by the public scrutiny of the health of those who were joining the armed forces at a time when Britain was at war. Thirdly, whilst the 1911 National Insurance Act was formulated, in part, as a response to the Report of the Commission on the Poor laws and Relief of Distress (1909), so the Beveridge Report (1942) raised the issue of health care reform on the policy agenda. Fourthly, adoption of new health care legislation could be seen to follow a significant change in party control, as the Liberals came to power in 1906, and the Labour party in 1945. Fifthly, the promotion and passage of these important pieces of new health legislation fell in both cases to highly competent, articulate, assertive and often abrasive politicians, Lloyd George and Aneurin Bevan. Finally, both the content and the implementation of the two acts were affected by the last minute threat of non-participation by the medical profession.

However, as in 1911 with the National Insurance Act, The National Health Service Act was passed in 1946 despite the problems and opposition that it faced. Last minute negotiations and compromises could be seen to have rescued the Act from the possibility of defeat although as with most compromises, some factions felt themselves to be losers in the debates. For whilst the medical profession had been to a large extent appeased, and were successful in achieving many of its aims, the local authorities and voluntary bodies were less successful when considering the outcomes of these last ditch negotiations. The medical profession was able to retain the option of private practice and access to pay beds was available for consultants, within the new NHS hospitals. Distinction awards, which could be seen to give a considerable financial incentive, and independent contracts for GPs were agreed upon, and doctors were assured of a major administrative role in the service at the expense of local government and the voluntary bodies who lost all control over their

hospitals. Abel-Smith (1964 p 480) recounts Bevan's comment that, in relation to the medical profession he had '*stuffed their mouths with gold*'.

As numerous health policy analysts have highlighted (Willcocks 1967, Klein 1989, Leathard 1990) those who were viewed as holding the monopoly of health care skills and thus could be argued to also hold the power to block change, were those who came out best in the negotiations which were to shape the final form of the new NHS, despite the fact that this could be seen to compromise certain policy objectives. In essence the structure and organisation of the NHS can be viewed as representative of a political compromise between the political aspiration for a national, comprehensive and equitable service free at the point of use and the desire of the medical establishment to maintain or even enhance its control, autonomy and income (Allsop 1984). These compromises which were made to ensure the co-operation of the medical profession can be seen to lay down some of the fundamental contradictions which were to become apparent in the NHS. It has been argued that, whilst some of these contradictions reflected political concessions, others could be seen to reflect a certain level of incompatibility of particular policy objectives which were only to become apparent at a later date. However the effect of such compromise was that the power relations and hierarchy which had long existed in health care services remained unchallenged and the organisational features which supported it were left in place when the NHS was established. Nevertheless, even though perhaps the changes were not as radical as once proposed, the task of implementing the 1946 NHS Act was a formidable one, as administrative structures had to be established and guidelines for the new service were prepared and published. A number of peripheral bodies had also to be established, both executive such as the Dental Estimates Board and advisory such as the Central Health Services Council.

The birth of the NHS

Following the trials and tribulations of both the legislative and the extra-legislative processes, the NHS came into being on July 5th 1948. It was, and remains, a major element of the post-war British welfare state. Although often attributed as a success of the post-war socialist government, it must be recognised that the NHS was a

product of wartime coalition government and of the consensus that existed at that time, about the role of the state in the re-building of post-war Britain. This unity was, in turn, a product of the social experience of war, the developing economic prosperity that could be seen to accompany peace, and the establishment of a coalition government which ensured that policy decisions were expedited without the delays usually generated by party disputes. The major effect of the transition from the wartime coalition government to the postwar Labour government, in relation to health legislation, was that Bevan replaced Beveridge's concept of a decentralised, pluralistic system with a centralised unitary system based on the hospital sector. It could be argued that Bevan replaced Beveridge's ideas for a National Health service with his own ideas for a National Hospital service. The pursuit of a unified service, can be seen to relate to the overall policy aims of this Labour government, and reflected a concern with inequalities in both health care services and access to these services.

Although the structure of the new NHS was shaped and refined during the negotiations following the publication of the government's plans for a nationalised health service, many of the original principles remained true to the original vision. The foundation of health care within the NHS was that it was comprehensive in provision, universal in terms of population coverage and free at the point of delivery. This can be seen to align closely with the aims of the image presented by the Ministry of Health (1944):

To ensure that everyone in the country - irrespective of means, age, sex or occupation - shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.....To divorce the care of health from questions of personal means or other factors irrelevant to it; to provide the service free of charge (apart from certain possible charges in respect of appliances) and to encourage a new attitude to health - the easier obtaining of advice earlier. The promotion of good health rather than bad. (Ministry of Health Cmnd 6502)

This service was to be funded mainly through general taxation, only a small proportion of the financing being raised through insurance contributions. It can be clearly identified that the NHS, at its inception, had three main operational objectives

sufficient and sound public financing of health care services, equitable and rational distribution of those services and planning and co-ordination of all health care activities.

Pater (1981) has identified five features of the new system which were both characteristic and at the same time controversial:

- (1) Three separate administrative channels - hospital bodies, local authorities and executive councils.
- (2) The nationalisation of all hospitals within the scheme.
- (3) The utilisation of appointed voluntary bodies in the administration of the NHS.
- (4) Free delegation of power from the centre.
- (5) Co-operative general practice - although it was to be at least two decades before this idea really got off the ground.

At the outset the structure of the NHS was a tripartite one which was, to a large extent, shaped by the historical legacy of the institutions involved in health care in Britain:

Although widely portrayed as a revolutionary departure, the National Health Service was in most respects evolutionary, or even traditional. For instance although originally conceived as a unified structure, the service was effectively split into three distinct component parts coinciding with the three nuclei around which health care institutions had aggregated in the course of the previous century. '(Webster 1988 p 2)

The hospitals were to be administered by the fourteen new Regional Hospital Boards, who along with the Board of Governors of the associated teaching hospitals and university medical schools would be responsible for the planning, provision and supervision of health care services in its own region. Executive councils took on responsibility for the family practitioner services, which encompassed not only GPs but also dental, ophthalmic and pharmaceutical services. These services were provided by individual practitioners who were paid on a contract basis directly from the Ministry of Health, payment being determined on a capitation basis. The local authorities became responsible for a range of personal and environmental health care

services which included maternity and child welfare, school health services, immunization and vaccination, health visitors, health education, home helps, the ambulance services and home nursing. These were funded both by central government grants and through local authority rates. The Ministry of Health provided the central control of the new health care system, passing funding down to the Regional Hospital Boards for distribution to the Hospital Management Committees, the Board of Governors of teaching hospitals, the Executive Councils for administration of family practitioner services, and finally to the local authorities in the form of grants.

The first three decades of the NHS

From the very beginning there were controversies and conflicts over state funded and state provided health care services. Many of the problems that emerged in the early days could be traced to two fundamental difficulties - financing and organisation. The problem of financing was perhaps the first to be recognised, and to cause serious concern, as it rapidly became apparent that it was to prove to be a formidable task to either predict or control. One of the major assumptions on which the NHS was founded was that there was a finite amount of ill health within the community, Beveridge (1942) used the term '*an untreated pool of sickness*'. The provision of health care free at the point of delivery would improve the overall health of the population and result in a reduced demand for health care as the total load of ill health was diminished. Bevan did not share this view and had a clearer vision of the financial implications of the NHS:

We will never have all we need. Expectation will always exceed capacity.

This service must always be changing, growing and improving, it must always appear inadequate. (cited in Foot 1975 pp 209-210)

Time was to show Bevan to be right, as the cost of the NHS was proven to be greatly underestimated, and the level of demand was unpredicted and uncontrolled. Consequently the cost of the NHS in the first year greatly exceeded the estimates, and at an early stage a supplementary estimate of £59 million for the first year appeared, soon followed by a further supplementary estimate of £98 million for the second year. This was a pattern which could be seen to be established over years which

Although some of the unexpected expenditure could be accounted for by an under-allowance for dealing with the backlog of demand for dentures and spectacles, this could not explain the extent of the under-estimation of the costs. These rose from £433 million in 1949 to £499 million in 1951 to £521 million in 1953, as it became ever more obvious that there would be no curtailment of demand, indeed it began to appear that it was probable that demand would continue to grow.

There was a growing concern for the ever-increasing costs involved in the new state system of health care. By 1951, just three years after the NHS was set up, one of the guiding principles of the service - that it should be free at the point of delivery - began to weaken as prescription charges were introduced by the Labour government. They have since remained a feature of NHS provision (Holliday 1995). The financial situation of the NHS was viewed with great concern, and led to the appointment of the Guillebard Committee of Enquiry in 1953. It was the remit of this committee to examine the prevailing and future cost of the NHS, and to suggest the means by which the most effective and efficient use of funds could be achieved, whilst at the same time attempting to suggest strategies for avoiding the continually increasing costs. The Guillebard Report (1956) utilised the research which had been carried out by Abel-Smith and Titmuss (1956) and drew the conclusion that there was no evidence of inefficiency or waste in the NHS, and that in fact the cost of the NHS relative to the proportion of the Gross National Product, had fallen from 3.75% in 1949/50 to 3.25% in 1953/54. The main critique of the committee was on the nature of NHS spending rather than the increase (Hayward and Alaszewski 1980). They argued that whilst spending was mainly on revenue items, there had been a failure to plan capital expenditure to deal with the fact that most of the hospital buildings were requiring extensive repair and renovation. The recommendation of the committee was that what was required was additional funding to provide for the necessary capital costs of providing the service, taking into account the fact that around 45% of all hospitals were over sixty years old and needing investment to control deterioration. This call for extra resources was one which was to be repeated both by individuals (Eckstein 1958, Abel and Lewin 1959) and by organisations (Acton Society Trust 1955-1959). However, despite this call for increased capital spending the 1950s

remained a time during which many services were offered in an environment which could be seen to characterise a culture of 'make do and mend' (Ham 1992). Yet, regardless of the continuing effort to attempt to control and curtail costs they continued, inexorably, to rise and thus remained a cause for both public and political concern. However, at the latter end of the 1950s and the beginning of the 1960s this focus on financing as the key problem of the NHS began to weaken, and there were the beginnings of an acceptance of the need for a degree of capital development, which coincided with an escalating focus on the administrative difficulties of the service.

It was not until the appointment of Enoch Powell as the Minister of Health in 1960, that the political strength of leadership which had brought the NHS into being, re-emerged, and his 1962 Hospital Plan demonstrated a government commitment to expansion in the hospital building programmes. At Powell's instigation the Regional Hospital Boards were required to produce development plans for their region, which were coordinated into a comprehensive Hospital Plan. This was collated alongside the local authorities' proposals for development of their health and welfare services and eventually presented by the Ministry of Health as - Health and Welfare: The Development of Community Care (1963).

Whilst during the 1960s the first evidence of strategic planning emerged, and there appeared to be a strengthening commitment to the NHS, demonstrated by the plans for capital development and the level of long-term planning which was being undertaken, a critique of the NHS developed in which could be discerned three distinct strands (Ham 1981). First, some health policy analysts began to question the whole concept of state funded, state provided health care. Perhaps the most coherent argument was developed by Lees (1961) who argued for health care to be considered in the same way as any other consumer good, to be bought and sold through the mechanism of the market, by means of a system of private insurance. The second challenge to the NHS came from the newly developed pressure groups which were organised by the users of the health care services. These groups which included among their numbers the Patients' Association, the Association for Improvements in

Maternity Services and the National Association for the Welfare of Children in Hospital, expressed a growing dissatisfaction with the way that health care services were managed. The third way in which the NHS was questioned could be seen in the report of the Medical Services Committee (1962) which concluded that while the essential concept was sound, the structure of the service was so unsound that it required a radical review. The challenge to the NHS at this time can therefore be seen to have been on three levels, philosophical, political and pragmatic, and can be seen to have provided the basis for the more direct challenge which was to follow in the next decades.

This growing discontent with the way in which the NHS was functioning was exacerbated during the latter half of the 1960s when increasing evidence of poor standards of care provided to certain client groups began to be revealed (Robb 1967, Ely Report 1969). Many of the problems which had begun to surface were blamed on the system of administrative control within the NHS. A fundamental difficulty in implementing central policies at local level was identified, and increasingly the solution to this problem was viewed as being a radical reorganisation of the administrative structures and processes of the NHS.

Two Green Papers (Ministry of Health 1968, DHSS 1970) were published to guide the consultation and debate over the form which the proposed new administrative structure was to take, once the decision to reorganise had been made. The second of these Green papers identified a clear policy objective for the reorganisation which related to one of the guiding principles of the NHS, that is the promotion of a more equitable distribution of health care resources:

Further levelling up of resources.....is needed to provide the same high quality of service all over England. There are also unjustifiable differences between the average standards of care provided for long-stay hospital patients - the elderly, the mentally ill and the handicapped - and the standards of care of the short-stay hospital patients. In the services paid for partly from local rates, standards of services also differ (DHSS 1970 p 1)

The proposals for an improved administrative structure and enhanced managerial

efficiency were presented as propositions from the DHSS and enshrined in the operational plans outlined in the Grey Book (DHSS 1972), later to be embodied in the 1973 National Health Service Act. The vision which gave impetus to the act was that the tripartite structure of the NHS which, it could be argued, had created and also perpetuated many of the problems which had beset the organisation, would be disbanded and replaced by a unified system of administration. Although there was a consensus that the easiest way to achieve this unification would be to transfer health care services to local government, it was also generally agreed that such an option was not feasible taking into account the political climate of the day, and the best available option was seen to be the alignment of the boundaries of health and local authorities. At the same time a more efficient and more effective system of management was to be promoted through a change in central/local relations, which, it was argued, would allow the delivery of health care services which would be more closely attuned to local needs. Three distinct policy aims can be identified in this proposed reorganisation. First was the unification of all services by the creation of Area Health Authorities. The second is to achieve closer coordination between health and local authority services and thirdly, to improve the managerial efficiency of the health service.

In 1974 the policy decisions enshrined in the 1973 National Health Service Act were implemented, and a reformed NHS emerged. But, not only did these times of change demonstrate a faith in the force of organisational change to improve efficiency and effectiveness in all spheres of government, but also an increasing frustration within the NHS at the seeming inability of central government to implement their policy decisions (Klein 1989). So the NHS underwent the first major change in its structure and organisation since its inception. Regional Health Authorities became the executive agency, mediating between the Department of Health and Social Security and the Area Health Authorities. The larger Area Health Authorities were then divided into smaller districts which were managed by a team of officers operating through a system of consensus management. Family Practitioner Committees were created to manage the activities of primary health care services, which were directly accountable to the Area Health Authority. An innovation was seen in the

development of the Community Health Councils which were viewed as having a consultative relationship with the District Health Authorities, representing the users of the health care services. All tiers of the service, Region, Area and District were advised by professional advisory committees which, it was envisaged, would improve the quality of decision making by improving the level of knowledge and expert opinion made available to the officers. For perhaps the first time within the NHS, this new concept of consensus management which had been introduced, gave the nursing profession as well as the medical profession, a fundamental part to play in the management of the delivery of health care services. It was noted by some policy analysts that the reforms which were implemented in 1974 marked a substantial extension of nursing power within the health service (Strong and Robinson 1990).

Although the major change during the early 1970s focused on the administrative difficulties of the NHS, this was also a time during which economic growth could be seen to slow down, and the relationship between the government and the NHS began to alter as government control over expenditure began to tighten (Gray 1993) and cash limits began to be introduced as the attempts to control public expenditure became dominant on the political agenda.

However, despite these attempts to divert the evolving sentiment that perhaps the NHS was an edifice which was fundamentally unsound in terms of administration and not viable in terms of the ability of the country to afford the increasing level of expenditure, these changes did not bring a solution to the two central problems of financing and organisation. Although structurally the NHS looked to be a new-style organisation, the functioning and therefore the existing problems remained relatively static. The overall intentions of the 1974 reforms can be summed-up in the slogan that was frequently used within the organisation 'maximum delegation downwards, maximum accountability upwards'. Regarding the financial position, this remained problematic and a source of constant controversy, and even if the essence of the problems which persisted to beset the NHS had been accurately pinpointed, the solution remained elusive and perhaps the attempt to satisfy everyone could be seen to lead, almost inevitably, to the dissatisfaction of all (Klein 1989).

CHAPTER 4

THE CHALLENGE TO THE NHS

The growing critique of the NHS

During the latter half of the 1970s, a growing discontent with the NHS could be discerned, across both the professionals and the politicians, whilst at the same time a number of controversial health issues entered onto the political agenda. Some of these were perceived by professionals within the NHS as a sign of a breakdown in the contract which had held between government and the health care providers, and in particular the doctors, since the inauguration of the NHS in 1948. Noticeable among these was the Labour government's attempt to phase out private practice within health service facilities, because it was a privilege which had been held by the medical profession since the NHS was established (a proposal which not surprisingly met with some considerable opposition). Perhaps the most significant of the government's responses to the discontent and disillusionment of the doctors could be seen in the setting up of a Royal Commission to examine the state of the NHS and present proposals for the future operation of the service. However, towards the end of the 1970s, and with the increasing likelihood of a change of government (which came about in 1979), a thorough overhaul of health care within the NHS could be seen as inevitable whatever the report of the Royal Commission.

This growing dissatisfaction with the NHS, and the subsequent attack on state provision of health care could be seen to stem from the increasing discontent over welfare provision in general, which ultimately led to a breakdown in the consensus which had held since the war (Loney et al 1987). Several reasons have been cited as being responsible for this break. First, the forced and severe cutback in public expenditure due to the 1976 IMF loan compelled a radical review of the level of public service provision, aligned with a growing recognition of the need to control if not reduce the level of public expenditure. Secondly, the general decline in the acceptability of Keynesian economics coincided with rapidly escalating inflation and

facilitated the acceptance of monetarist economic policies. Thirdly, there was a universal erosion of faith in the welfare professionals, a decline in popularity which could be seen to be accelerated by a number of revelations in the media which appeared to demonstrate incompetence, inefficiency or outright failure of the professionals to meet the needs of the service users (Kavanagh 1991). So began a radical review of the ways in which health and welfare services were provided. Finally, and possibly most telling, a coherent and articulate critique of the concept of state welfare provision developed from the New Right. At the heart of this critique was the notion that the collective provision of health care, as of other welfare services, led to the development of the so-called 'nanny state' which, it was argued, fostered dependency and stifled individual initiative. The New Right claimed that through the imposition of uniformity and bureaucracy the NHS, as other welfare institutions, was anti-individualistic and functioned in a way which could only curtail the freedom of individuals.

This critique was particularly telling in that it developed during a time when there was an unprecedented escalation in demand for health care services which it was impossible to meet within existing, restricted resources. A number of factors exerted an influence on the level of demand at this time, and indeed have continued to do so (Kavanagh 1991). Demographic changes greatly affected the pattern of demand for health care. The continuing fall in both the birth and the death rate created an ageing population with a greater likelihood of living out their latter years with some level of ill health or disability (Palmore 1977). Aligned to this, there was a decrease in family size over recent decades, and increased geographical mobility. Both these factors have considerably lessened the availability of family to take on the caring role for its older and disabled members. Other social changes, such as the increasing inclusion of women in the workforce can also be seen to have had an impact on the patterns of family provided health care (Ungerson 1990).

Continued, rapid developments in medical technology, particularly in the fields of pharmacology, medical diagnostics, transplant surgery and neo-natal care had increased the areas of ill health which were now amenable to medical intervention.

Not only were the research and development costs of these advances high, but this was reflected when the new technology was applied to patient care, and it was, and continues to be the case that not only are the capital costs high, but also the recurrent running costs. Such developments also required advanced education and training for the health care professionals and technical support staff. Also, the NHS, whilst a public service, relied on the acquisition of a vast array of resources from the private sector much of which could be seen to comprise of monopoly suppliers. This severely limited the ability of the NHS to control let alone curb costs.

Whilst the NHS was constructed around an essentially low paid workforce, with the exception of the powerful, but relatively small number of medical staff, there was continued pressure for improved pay and conditions for NHS employees. This escalated during the 1970s, and was generally supported by the general public. Finally, it was argued by some that, as the population became more accustomed to receiving state services, the fact that health care was free at the point of delivery meant that there was no effective curb to demand and thus health care demand, in the context of the NHS, was destined to be infinite, and thus demand for health care would inevitably be at odds with the resource limitations with which the NHS was faced (Wicks 1987).

The critique of the New Right was founded on one vital belief - that private possession of health and welfare goods and services was always better than public provision (Wilding 1987). Private ownership, it was argued, was better in three ways, socially, politically and economically. Socially it was viewed as superior because it did not encourage dependency or suppress initiative, and offered individual freedom of choice. Politically, private ownership was preferred because it prevented the government from becoming the agents of any particular interest which would prevent it from acting in the best interests of the country as a whole. Economically it was seen to be better in that it was not so damaging to the economy by being a drain on the public purse, whilst at the same time being both more efficient and more effective, motivated by the competition of the market. It can be seen therefore, that when the Conservative government took over power from the Labour government in

1979, it also took over responsibility for administering a system of health care to which, fired by the ideology of the New Right, it no longer held any ideological commitment, although of course political expediency required that they sought reformation rather than destruction.

From 1979 four distinct themes can be recognised in relation to welfare services in general and health services in particular (Mahon 1995). Firstly, the intensifying of the critique of bureaucracy, and the evolving belief in the inefficiency of the public sector. Secondly, the attacks on union and professional power and thirdly the focus which centred on the concept of 'value for money' aligned with efficiency and effectiveness. Finally can be discerned the continued attempts to withdraw the state from a number of welfare responsibilities through a refocusing away from the state and onto the market, the community and the family as the major providers of care for those in need.

The impact of the economic crisis of the 1980s on the NHS

The economic crisis of the 1970s worsened as Britain entered the 1980s, and so the competition for scarce public resources became an increasing struggle to avoid budget cuts rather than a contest to secure extra resources, and the government's commitment to the market system for the provision of health and welfare services became more resolute. However, despite the necessity of stringent cuts in public expenditure, the NHS did appear to enjoy a level of protection from cuts not afforded to other welfare services, for although the level of investment spending fell, the budget for services was not reduced. The total cost of the NHS rose from £9282 million in 1979 to £19801 million in 1986, an increase of the share of Gross National Product from 5.4% to 6.1% .

The focus of the government on the system of social security, which it was believed held the greatest potential for reduction in public expenditure at minimum political costs, and the significant reduction made in relation to housing, resulted in the NHS being able to avoid, to a large extent, the fall of the financial axe, if only for a limited period. However, the threat remained, because despite this increase in

expenditure at a time when it was being cut back in almost all other areas, this was not a reflection of any government belief that the NHS was functioning successfully. Indeed, as the Reforms of 1974 seemed to have satisfied no-one and failed to have achieved the improvements which had been targeted, so there was a continued drive for administrative and managerial efficiency and effectiveness. The report of the Royal Commission on the NHS which had been set up by the Labour party just prior to its electoral defeat was awaited with some impatience, as it became ever more obvious that the NHS was out of control in terms of spending, and in a state of disorganisation in terms of administration. What was, perhaps, to prove to be somewhat of a surprise was the level of support given to the NHS:

We are all too conscious that our report will be disappointing to those who have been looking to us for some blinding revelation which would transform the NHS. Leaving to one side our own capacity for revelation of this kind, we must say as clearly as we can that the NHS is not suffering from a mortal disease susceptible only to heroic surgery. Already the NHS has achieved a great deal and embodies aspirations and ideals of great value (Merrison Report 1979 p 355)

However, despite this support from the Royal Commission, the fundamental problem facing the NHS, and indeed a problem which had been evident for thirty years, clearly outlined and clearly articulated, was the fact that no longer could health care services maintain the principle of comprehensiveness:

The demand for health care is always likely to outstrip supply and....the capacity of health services to absorb resources is almost unlimited. Choices have therefore to be made about the use of available funds and priorities have to be set. (Merrison Report 1979 p 51)

The Health Services Act of 1980, in response to the Merrison Report, created the legislative framework that resulted in the abolition of one tier of administration, that of the Area Health Authority, which had featured so prominently in the 1974 reorganisation. This new reorganisation was completed in 1982 with the creation of 201 new District Health Authorities, which took on the responsibilities of the Area Health Authorities, and were advised by, and accountable to the Regional Health Authorities. The only other major structural change in this reorganisation was in the

creation of the Special Health Authorities. Two major changes to the financing of health care services were also introduced. Firstly Health Authority cash limits became legally binding and secondly Health Authorities were empowered to set up charitable appeals for funds, the cost of which could be recouped from the proceeds of the appeal. It was also in 1982 that a Central Policy Review Staff report was leaked, revealing that serious consideration had been given to replacing some welfare programmes with private alternatives, including the possibility of an insurance system for health care. However, following an unfavourable public reaction, this was speedily disowned by the government, who recognised the impact of the message of public support for the current system of health care provision.

The introduction of general management into the NHS

The time during which the model of administration embodied in the 1982 reorganisation took shape remained a time of both dissatisfaction and disruption. The government had to convince the electorate of their commitment to the NHS which had been stressed during their 1979 election campaign, for there remained strong public support for the NHS, and a continuing level of popularity which was not reflected in public opinion of other welfare services (Taylor-Gooby 1985). It was perhaps political astuteness rather than any other factor which kept at bay any further major changes to the NHS until after the 1983 general election in which the Conservative government gained an overwhelming majority.

The government had not, however, dispelled their doubts about the efficiency of the NHS and continued to challenge the ability of NHS management to provide health care which was at the same time effective and economically viable. Roy Griffiths (later to become Sir Roy Griffiths) who was at that time managing director of the Sainsbury's supermarket chain, was asked to head an inquiry into the management of the NHS. The Griffiths Report (1983) can be seen to be an example of streamlining the extra-legislative process by being published after having completed the task set in only six months, and involving only four people. The government justified its approach in a press release:

Four leading businessmen are to conduct an independent management Inquiry

into the effective use and management of manpower and related resources in the National Health Service....we are setting the Inquiry two main tasks; to examine the way in which resources are used and controlled inside the health service, so as to secure the best possible services for patients....to identify what further management issues need pursuing for these important purposes.....we have gone straight for management action, with the minimum of fuss or formality. (DHSS 1983a)

The report highlighted four main findings which were to shape the next major reorganisation of the NHS. First, the Griffiths Report was highly critical of NHS management at all levels, viewing it as inefficient, ineffective and poorly focused on the job in hand. It argued that the lack of drive was largely because at each level of management there was no one person responsible for action. Secondly, it concluded that the Department of Health did not provide effective leadership, and so had failed to initiate solutions to long-term problems within the service. Thirdly, it was argued that the pattern of consensus management which had evolved through the 1974 reorganisation was failing to deliver the motivation which was necessary in such a large and complex organisation, and that delays were caused by the slow pace of decision-making. Finally, it said that hospital doctors, whilst accepted as a powerful force in the provision of health care, were playing too small a part in the management of the service. Recommendations included the reinforcement and streamlining of central as well as local management, through the establishment of both a Health Services Supervisory Board and an NHS Management Board within the Department of Health and Social Security, with the Chairman of the Management Board being drawn from outside the sphere of the NHS or Civil Service. The Griffiths Report made quite clear the underpinning assumption that the NHS, despite its complexity, should be treated as similar to any other organisation, and that a business model of management was pertinent for the proposed reorganization:

The clear similarities between NHS management and business management are much more important (than their differences). In many organizations in the private sector, profit does not immediately impinge on large numbers of managers below Board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity,

motivating and rewarding staff, research and development, and the long-term viability of the undertaking. All things that Parliament is urging on the NHS.
(Griffiths 1983 p 10)

The debate which was to follow the publication of the Griffiths Report developed several strands which can be discerned in the professional journals at that time. First, there appeared to be a strong defence of consensus management, as the vehicle by which all professional groups could be represented in the management of service provision. Secondly, although there was a substantial agreement with the diagnosis of the Griffiths Report in relation to the shortage of managerial strength in the NHS, no such agreement emerged as to how this should be addressed. Finally, there was much opposition to the concept of general management, but as has been highlighted, much of this opposition was poorly focused in that it centred *‘inordinate attention on the role and personage of the general manager rather than on the function of general manager.’* (Parston 1988 p 22) and to a certain extent articulate debate was replaced by individual professional organisations laying claim to general management for its own members.

However, despite the on-going debate, the government’s response to the Griffiths Report was as rapid as its preparation, and by June 1984 Health Authorities were instructed to establish a general management function and to employ general managers (DHSS 1984). As Leathard states:

The overall significance of the Griffiths model was the intention to promote and control change in a much more positive and centralized manner. It was about transferring the NHS into a managed service rather than merely an administrative service. (Leathard 1990 p 85)

Indeed the move towards general management could be seen to embrace the ideology of the New Right:

That new philosophy in many ways embodies the very essence of Thatcherism. The notion that professionals should be subject to the same kinds of accountability and control as are found in contemporary business hierarchies is central to modern Conservative doctrine. (Holliday 1995 p 15)

These new style general managers of the NHS would, it was argued, lead to a more purposeful management style facilitated by appointments being made on short term contracts and the introduction of structured performance appraisal and performance related pay (Best 1987). The providers of health care services had, yet again, to come to terms with a radical reorganisation during which resources had to be diverted from the direct provision of care to the structural reorganisation which was demanded of them. Perhaps to a greater extent than in previous reorganisations, the effects were quickly felt at the 'grass root' level, as the new general managers made their presence felt within the organisation. As these new managers were on short-term contracts, and their pay was performance related, there was no time for a 'honeymoon' period. Changes were made swiftly, and the relatively slow pace of change which had been dictated by the consensus management process was swept away. For many health care professionals the introduction of budgetary controls and, in 1986, the introduction of resource management, initiated many changes in professional practice. The devolution of elements of budgetary responsibility to clearly designated unit teams gave both doctors and nurses a more significant role in the management of both human and material resources. The impact of general management, and the importance which the general manager would assume was well recognised:

General management was founded on a new type of health service trade, the professional manager; a manager who was dedicated solely to the interests of the entire organization, not just to one of its parts. (Strong and Robinson 1990 p 24)

The reaction to the introduction of general management into the NHS was ambivalent, as can be seen in the transcripts of the interviews carried out by Strong and Robinson (1990) in the course of their research into the changing style of management in the NHS. Some were very impressed with the changes like the Regional Nursing Officer who declared:

Griffiths is the best thing since sliced bread! It (NHS management) was a lot of bloody nonsense before! Nobody put their head over the parapet. It was just a talkshop, a devilish waste of money. Nobody took on the clinicians. (Strong and Robinson 1990 p 66)

Others, however, were more critical of what they saw to be a growing bureaucratization, which it was argued, hindered the delivery of health care services, like the Director of Nursing who stated:

I can't say that I enjoyed having a UGM (Unit General Manager) The individual is fine. If I have to have one he's as good as I'll get. But for the first time I'm responsible to a non-nurse and I have to put the case for things to an executive board - which irritates me. There's less freedom....now I have to explain things to non-nurses and that takes longer and they may see things differently. (Strong and Robinson 1990 p 76)

The mixed response to the implementation of the proposals put forward in the Griffiths Report was perhaps, understandable, for whilst the management structure was new, many of the managers were the former hospital administrators with a new title. In response to a question raised in the House of Commons it was revealed that of 744 general managers at Regional, District and Unit level, only 84 came from outside the NHS (Hansard 1986). This can perhaps be seen as a reflection of the doubts which existed as to the belief that a general manager without direct experience of the complexity of the NHS could achieve the success which was expected of the reorganisation. Despite the attempts to strengthen leadership at central level, the changes which were introduced as a response to the Griffiths Report appeared to have little effect, for the Supervisory Board met rarely, and could not be seen to provide the level of strategic leadership which had been envisaged by Griffiths (Ham 1992). Whilst the Management Board was apparently more successful in providing the necessary management leadership, the fact that they were largely divorced from the policy process which still rested with the Department of Health Policy Group, could be seen to create difficulties in achieving a coherent approach which embodied both policy decision making and policy implementation. It has been suggested that this could be viewed as a reflection of the success of established civil service interests in preserving for themselves a major role in the formulation of health policy (Ham 1988).

The growth of managerialism in the NHS

Despite the persistence of existing problems, and the emergence of several new problems following the implementation of the proposals put forward in the Griffiths Report, the belief that a strong, effective and efficient management structure was the only viable solution to the troubles which beset the NHS endured, certainly within the government. Throughout the 1980s new management structures, programmes and technology swept through the NHS. The report of the Korner Steering Group (1982) which examined the use of information systems within the NHS played an important part in the rapid progress of the new mode of managerialism, in that the complexity of the NHS necessitated the collection, dissemination and utilization of vast amounts of health services activity data. It has been suggested that one major impact of these changes was that more overt rationing, based on objective economic principles and data technology, replaced what had been the more covert style of rationing of scarce resources by health care professionals on more subjective clinical data (Leathard 1990). Further evidence of the developing managerialism can be seen in several other initiatives during this time (Harrison 1988):

- (1) Efficiency savings were decreed by the Secretary of State which were to rise from 0.2% of the budget in the 1981/82, to 0.5% of the budget in 1983/84.
- (2) An annual review process was instituted in 1982 which would monitor and review the operation of the NHS.
- (3) The Rayner scrutinies which had been introduced to the Civil Service in 1979 were extended to the NHS in 1982. This entailed rapid reviews of efficiency along with recommendations to secure added value for money.
- (4) Centralized manpower control was established in January 1983.
- (5) The first list of health service performance indicators was published in the latter half of 1983, which outlined the measures by which performances would be measured and compared in over seventy areas of clinical activity, support services, finance, estate management and manpower.
- (6) Forced disposal of property which was deemed to be surplus to the

requirements of the service emerged as an important concern of the government during the mid 1980s.

This pattern of managerial control can be seen to be consistent with the government's belief in the potency of competition as a driving force of the organisation, because many of the new initiatives provided a framework for comparison between both Health Authorities and hospitals:

Enable comparisons to be made between districts and so help Ministers and the Regional chairmen....to assess the performance of their constituent.....authorities in using manpower and resources.

(DHSS 1982 p 2).

This was an overt part of government strategy, and possibly the significance of this approach did not become apparent to the health care providers for some time.

For many medical staff, the implementation of the Griffiths model of general management and the rise in managerialism was viewed as being the beginning of the end of clinical freedom, for no longer did clinical decisions remain unquestioned and unchallenged. The creation of clinical performance indicators made it possible for the work of hospital consultants to become both visible and measurable for the first time, whilst at the same time general managers could be seen to challenge the long held assumption that only doctors could legitimately speak on behalf of their patients, or to assess their needs. Operationalisation of the systems of management budgets could also be seen to create the potential for general managers to impose management priorities on individual clinicians. Whilst, on the one hand, the medical establishment expressed a wish to see doctors taking on the role of general managers, which to an extent could be seen to overcome the potential loss of clinical autonomy, on the other hand doctors who became general managers often found that much of their clinical activity became subsumed by the demands of management, a situation which was many disliked (Petchy 1986).

Although in some ways Griffiths can be seen to have posed a threat to the long established power of the medical profession, the degree of power which had more

recently been acquired by the nursing profession was under an even greater threat. For, although nurses had acquired a significant position in the management structures following the reorganisation of 1974, this would be unlikely to be retained unless they were able to secure position and prestige within the general management structure, or at least be able to secure adequate representation. The degree of their success, or rather lack of success in securing these objectives can be seen reflected in the fact that only 2.8% of general management posts had been filled by nurses in 1985, although this had risen to 11% by 1987 (Leathard 1990), and there is much evidence to suggest that nurses, and especially female nurses, were at a distinct disadvantage in the battle to procure senior posts within the general management structure (Glennister et al 1988, Millar 1989a), and thus became to a large extent marginalised from decision making at a senior level within the organisation both at central and local level. Not only was this recognised by the two main professional groups within the NHS, doctors and nurses, (and the Royal College of Nursing mounted a memorable campaign of opposition), but also by the managers:

There was, then, an extraordinary contrast in managers' eyes between the individual power of doctors and the collective feebleness of nurses; between medicine's influence at the highest levels and nursing's notional representation; between doctors' fierce syndicalism and nursing's massive internal hierarchy. (Strong and Robinson 1990 p 39)

The new style of general managers could be seen to be beginning to construct a stereotypical belief in the reluctance of doctors to manage and the lack of ability of nurses to manage, which could be seen to leave a clear path for these new managers to procure and preserve control within health care provision services. In many ways, the professional perspective was viewed as an essential component to service delivery. It was also seen as a threat to the organization. The new style managers perceived the professionals as holding a parochial rather than the global perspective which was viewed as being the pre-requisite of a healthy organisation. At a very early stage in the implementation process it became obvious that professional individualism and in particular, medical individualism would no longer be supported, or even tolerated by the new regime. However, possibly the degree of cultural change which would be necessary for professional health care staff to develop the required corporate approach

to the organisation was underestimated, and thus the extent of the change was perhaps less complete than was initially envisaged:

The prime determinant of the pattern of the health services is still, just as before Griffiths, what doctors choose to do. (Harrison 1988 p 123)

As the government pressed on with the changes initiated by Griffiths, it also continued to develop those ideas relating to a pluralistic approach to the provision of health care services, and the ideology which formed the foundation of the health policy of the New Right viewed the private sector as having an important role to play in the health care system in Britain. Many could be seen to regard the private sector as enhancing the care which could be provided within the NHS in three main ways (LeGrand and Robinson 1984). Firstly, it was argued that the private sector, by expanding the overall level of health care facilities available in Britain, would ease the pressure of ever increasing demand. Secondly, it was claimed that the existence of a flourishing private sector increased consumer choice and thus enhanced individual freedom. Finally, it was maintained that only with a significant private health care sector could the risks of the NHS as a monopoly supplier of health care services be reduced. During 1983 the private health care sector received a significant impetus to expand as the government actively encouraged the furtherance of partnership deals between the public and the private sector. It was also during 1983 that a directive was issued which charged that domestic, catering and laundry services within the NHS should be subject to tendering to private contractors in an attempt to secure more cost effective services. The growing commitment to the development of competition in health care between the public and the private sectors, and indeed the expansion of the private sector in health care, was highlighted in a speech by Lord Wigoder in a debate on the NHS in the House of Lords:

The existence of the two sectors stimulates competition, competition in the design and building of hospitals, competition in the use of day surgery, developments in preventive medicine and so forth. (Hansard 1983 Col 974)

The introduction of what could be seen to be a modified business model into the NHS, whilst fulfilling some of the policy aims of the Conservative government, was not an unqualified success. For although some research suggests that better health care could be provided under the leadership of a new style general manager (Strong

and Robinson 1990), it has also been implied that this apparent improvement was only achieved within the hospital sector at the expense of the community sector which, it has been argued, suffered from neglect (Carrier and Kendall 1986). A study by Harrison (1994) revealed that general managers have been relatively lacking in influence over doctors, and that only *'modest changes in this relationship have taken place as a result of the introduction of general management.'* (Harrison 1994 p 122). However, in relation to non-doctors the influence was seen to have been enhanced and more far-reaching. Respondents in this study were largely affirmative in their response to general managers, legitimising their role as preferable to consensus management. An issue that came to gradually draw more attention was the possibility that implementation of the Griffiths recommendations, rather than ensuring managerial control over the professional groups within the NHS, actually created another group, that consisting of general managers, a point which was recognised by Griffiths himself:

Whilst my name at the time was primarily connected with general management, I personally took this as shorthand for the introduction of an effective management process. I did not intend that the result should be yet another profession in the National Health Service. (Griffiths 1992 p 65)

What is certain is that the implementation of the recommendations of the Griffiths Report, whilst dealing in many respects with the perceived faults of the management system, failed to achieve any real success in terms of the ever increasing cost of running the service. NHS expenditure continued to rise from £17,241 million in 1984 to £23,627 million in 1988. Notwithstanding that the impact of inflation had a severe effect on the NHS, as of any other organisation, this level of increase was not one which the government was willing to sustain.

Despite intensive, and sometimes harsh, cost improvement drives, managers within the NHS appeared to have little if any control over the level of expenditure and the escalating costs. Although in some respects, the cost improvement programmes can be seen to represent a remarkable record of activity (Robinson 1988), saving as they did around 1.5% of total expenditure, this did cause some reservations, particularly among the professional groups working in the NHS, who began to voice their

concerns that the continued drive for efficiency and savings was beginning to have a detrimental effect on both the level of service provision and the quality of care that was being offered within the NHS. Despite this cautionary note cost improvement drives were pursued with increasing vigour as during the latter half of the 1980s funding assumed an ever greater importance, as there developed a widening gap between the funding provided from government and the funding which was required to expand the service to meet the growing demand for health care services.

The strengthening of the New Right ideology

Re-election of the Thatcher government in 1987 was to have far reaching implications for the NHS, for as the government majority increased so did the ideology of the New Right strengthen and consolidate, and as it did so the welfare state came under an increasingly determined challenge. The Conservative Party manifesto in 1987 had made it quite clear that the thinking on the key principles which should underpin the welfare state had moved on during the previous four years in power. Several strands which would prove to be important to the NHS can be identified:

- (1) The belief in privatization was consolidated and epitomised in the encouragement which was to be given to private pension plans. Subtly but significantly, the reliance on the welfare state was being eroded as stringent targeting was to encourage individual responsibility and independence.
- (2) The move towards centralization which could be identified in the diminishing powers of local government embodied in the shift allowing tenants to transfer from local authority to private housing provision, and higher education institutions and schools being allowed to opt out of local government control.
- (3) The standards by which health and welfare services would be evaluated were to reflect the value placed on efficiency and cost effectiveness, rather than the traditional values on which they had previously been judged.
- (4) Reduction of income tax at the cost of reduced public expenditure, embraced the values of individualism over collectivism, whilst

attempting to curtail dependency.

However, despite evidence that the government was steadily enshrining the values and beliefs of the New Right into the welfare state, it faced particular problems in relation to the health service. One of the major difficulties arose from the problem of legitimising the existence of inequalities in relation to health care, which was to prove to be far harder than legitimising inequalities in other areas of welfare provision and many of the arguments of those who opposed government management of the NHS focused on the unjustness of rationing and curtailment of services. Whilst it was true to say that the government was challenging the NHS during the latter half of the 1980s, it could also be seen that the NHS was constructing its own challenge to the government, and it was this challenge, surprising in its ferocity which provoked the Thatcher government into undertaking an in-depth internal review of the operation of the NHS (Butler 1992).

In 1987 when the funding problems in the NHS reached a critical situation, a National Association of Health Authorities Report (1987) detailed an apparent crisis in service delivery, citing evidence of closed wards, cancelled operations and a freeze on staff vacancies. As outlined in a Kings Fund Report (Ham, Robinson and Benzeval 1990) this dilemma prompted the Royal Colleges of Physicians, Surgeons, and Obstetricians and Gynaecologists, in a singular move, to issue a joint statement claiming that the NHS had almost reached breaking point and that unless additional funding was forthcoming, then collapse was imminent. The Labour party, during this time, maintained a sustained attack on the government which focused on the 'underfunding' of the NHS (Waine 1991), and the failure of government to face up to the worsening crisis in health care. Although the government responded vigorously to this attack, in the main by focusing on improvements in outputs rather than by concerning themselves with perceived deficiencies in inputs, a stalemate was reached. As Klein (1995) highlighted, the debate over the provision of health care at this time could be likened to a '*dialogue of the deaf*' as opponents utilised their own explanatory frameworks, their own language, and their own ideological positions to construct their arguments, and so in the final analysis there could be no consensus as to the parameters of the debate, and therefore no possibility of resolution.

The situation was quite obviously untenable for the government, as it was seen that despite all their efforts to reverse the situation, the NHS continued to fail to show improvements in relation to either the control of expenditure or the meeting of health care demand. In fact, in many respects it could be argued that the situation was worsening as the gap between funding and demand for health care services continued to widen, despite the attempts to curb this increase, added to which the increasing political, professional and public pressure which was being exerted was making itself felt. The government response to this political crisis was two-tailed, firstly a further £101 million was allocated to deal with the most pressing needs, and secondly the Prime Minister initiated a broad review of the future of the NHS, the results of which were promised to be available within the year, and which was to prove to be the initiator of the most far reaching reforms into health care provision within the NHS yet seen.

One of the effects of the financial squeeze of the early 1980s was that Health Authorities had become noticeably more efficient, but two strategies had become increasingly commonplace, which were somewhat harmful, or at least held the potential to be harmful to the government (Timmins 1995). The first of these was a development of a tendency to close beds and even wards in the last quarter of the financial year, and the second was the growing inclination to delay the payment of bills falling due during this last quarter of the year until the beginning of the new financial year. Of course this led to increasing amounts of debt being carried forward each year as spending continued to increase and budgets became stretched to their limits. A situation which exacerbated the worsening financial situation in the NHS was that the government, in a pattern that was to become the norm, had failed to fully fund the pre-election pay increases so leaving the Health Authorities with a significant increase in their wage bills to be met out of already over committed budgets. There began to be talk of 'inevitable rationing' (Independent June 12th 1987 cited in Timmins 1995) and hospital bankruptcies. As the financial crisis deepened the political situation worsened, and in what may be viewed as a last-ditch attempt to recoup some degree of command over their predicament the government made some decisions which were to be to their political disadvantage at very little benefit to the

financial crisis. The discontinuation of free eye and dental check ups was to be seen to have virtually no effect on the overall budget of the NHS, but was to prove to be exceptionally unpopular with the electorate, and whilst this may not have been reflected in the polling stations, it made it increasingly difficult for the government to maintain their position of commitment to the principles which underpinned the NHS, and thus a significant degree of support for their position on the NHS was lost (Timmins 1995).

Paving the way for health care reform

Disregarding the government's view of the performance of the NHS, it had always to consider the views of the electorate, who had traditionally responded negatively to any suggestion that the provision of NHS health care should undergo any radical change. In 1986 the British Social Attitudes Survey demonstrated strong public support for NHS spending, and 84% of those surveyed considered the provision of health care services as a legitimate responsibility of the government, whilst almost 50% chose the NHS as their top priority for additional spending, which represented an increase of 13% since 1983. This growth of support for more spending on health extended across all political parties (Taylor-Gooby 1987). An opinion poll commissioned jointly by the National Association of Health Authorities and the Health Service Journal in April 1988 demonstrated this strength of feeling (Davies 1988a). This survey showed that in all social classes and in all age groups there was unanimous agreement that the NHS should receive more funding, and that of all respondents who had used the NHS, or whose families had, 87% were fairly or very satisfied with their treatment. So although the government's political philosophy did not rest comfortably with the existing system of health care provision in Britain, it was generally accepted that any attempt to disband the NHS would be tantamount to political suicide, and the difficulties involved in taking on the NHS, in terms both of public support and professional power were well recognised and articulated:

The National Health Service is the closest thing the English have to a religion, with those who practice in it regarding themselves as a priesthood. This made it quite extraordinarily difficult to reform. (Lawson 1992 p 613)

Thus whilst they earnestly sought a solution to this situation, they continued to pronounce a strong commitment to the NHS, and it was, perhaps, this apparently paradoxical situation which prompted the most sweeping reforms that the NHS had yet experienced. The government was left with no viable option but to set up an NHS review, notwithstanding the problems that this posed:

It was the review that nobody wanted: NHS professionals for fear of what it would bring, the government because it had no clear idea about what it wanted to do to the NHS, and the public who still did not trust the government with the service. (Timmins 1995 p 458)

The announcement of the NHS review, which in an unprecedented move was announced by the Prime Minister during a television interview, led to widespread speculation that the government would utilise this to promote a radical alternative to the funding and provision of health care services. However alternative modes of financing had already been rejected in 1982, following the report, which remained unpublished, of a working party which had been set up by the Prime Minister, to examine possible options. The government were left with no alternative at this time other than to reject major changes to the system of funding health care largely from general taxation when they considered the findings of the working party:

In many ways our centrally run, centrally funded system was the most effective in controlling costs. There was no inherent cost advantage in moving over to an entirely new financing system and it was also clear that whatever system was chosen, taxation would still have to finance a giant share of the system. The unemployed, the poor, the chronically sick and disabled and of course children would need to be covered by public money. (Fowler 1991 p 184)

Possibly the speculation was enhanced by the nature and process of the review. It was noticeable that this major review of the NHS was very much an 'insider job' and thus could be seen to be bordering on the secretive. The business of conducting the review was left to five ministers - John Moore and Tony Newton from Health, Nigel Lawson and John Major from the Treasury and the Prime Minister herself. Roy Griffiths acted as the Prime Minister's personal advisor, but otherwise the review team's support was strictly limited to a select group of deputy secretaries and policy

advisors. However, whilst the review was conducted in private, that it was being undertaken at all prompted a large number of both organisations and individuals to proclaim their own views on the direction that the review should take (Ham 1992). Indeed, it could be seen that this open debate was actively encouraged, as the review team advocated public participation in the discussions on the possibilities for NHS reform (Holliday 1995).

Despite the government's ideological commitment to the idea of a market in health and welfare services it is noticeable that the internal review panel had been given a remarkably free hand in the development of proposals for NHS reforms and were not constrained as to the forms that these could take:

Far from steering a pre-set course, the Review tacked rather erratically between different options, only settling down to developing something approaching a coherent package towards the end of its existence. There was certainly an ideological bias among many of those taking part, in that they tended to share a belief in the merits of markets and competition. But there was nothing like an ideological programme....There were lots of problems in the NHS; there was a long list of possible solutions. (Klein 1995 p 188)

However, as may be expected, there is evidence that the review team were more influenced by the proposals for reform suggested by the New Right think tanks such as the Centre for Policy Studies, and the Adam Smith Institute than by the suggestions from other individuals and organisations less sympathetic to the prevailing political ideology. This ideology was strongly represented in the two publications which arrived at similar conclusions, and recommended parallel proposals for the creation of an internal market in health care without changing the fundamental system of financing from general taxation (Goldsmith and Willetts 1988, Pirie and Butler 1988), despite such a proposal having been discussed and rejected by the NHS Management Board just two years previously (DHSS 1986a). This concept of the internal market can be seen to have strongly influenced the review team when they prepared their proposals for reform. Although, again there was much interest in alternative methods of financing (Green 1988), no proposals were made which could overturn the findings of the 1982 working party, and the subsequent support for taxation as the

principal means of funding the NHS; indeed support for the current mode of financing was again sustained: *'there was surprisingly little we could learn from other systems'* (Lawson 1993 p 616). At the conclusion of the review again the focus returned to ways by which scarce health care resources could be used more efficiently and effectively, and so the argument pertaining to the perceived 'underfunding' of the NHS by those opposed to government policy on the NHS was effectively dismissed as irrelevant. The importance that the government attributed to bringing the NHS under control, and their commitment to a radical solution was perhaps reflected in the way in which the Department of Health was separated from the Department of Social Security during the time at which the NHS review was being undertaken, thus paving the way for Kenneth Clarke as the new Secretary of State for Health, replacing John Moore, to be able to give his entire attention to the NHS at a time which was one of both critical change and political consolidation. It can be noted that whilst the review was underway the picture of an NHS on the verge of collapse began to recede, indeed the BMA could be seen to withdraw from a call for a radical review of health care services and reconfirmed the medical profession's belief in the NHS, and at the same time their opposition to any form of rationing in relation to health care services:

The principles on which the NHS is based represent the most efficient way of providing a truly comprehensive health service, while at the same time ensuring the best value for money in terms of the quality of health care.

(BMA 1988 p 1411)

It could be argued that as a radical overhaul of the NHS appeared to be inevitable, then even those who had strongly criticised the way in which health care was being provided began to *'take fright'* (Klein 1989) at what might be to come. It was as if the realisation had become apparent that the break-up of the all-party consensus which had emerged since 1979 was going to create a new style NHS which would have to align with the political ideology dominating the Thatcher government. It was not the radical nature of the changes that had already taken place, nor the threat of those to come, but the strength of the political will to change and the opportunistic way in which this was pursued which was to become the focus of concern:

It is not the case that most of the changes have been particularly remarkable, or that a consistent strategy lies behind them. While one could no doubt

construct with hindsight quite a convincing account of such a strategy, it seems more consistent with the facts that the administration has been strongly influenced by opportunities as they have presented themselves, and even by the individual views of Ministers, Sir Roy Griffiths and senior civil servants, so long as they were compatible with the government's broad philosophy.
(Maxwell 1988 p 188)

Throughout the time leading up to and during the review of the NHS it became increasingly evident that the government's preferred option, to keep the NHS out of the political and ideological spotlight was not a viable option in view of the growing public debate, and electoral concern. So it was that the proposals for a radical reform of the NHS were to be revealed 'centre stage', and were to remain prominent on the political, professional and public agenda for some considerable time.

CHAPTER 5

REFORMING THE NHS

The proposals for reform

Following the deliberations of the internal review panel on the future of the NHS, plans for the most sweeping reforms yet experienced were introduced in a White Paper, *Working for Patients* (DoH 1989a). These proposals along with those which had been introduced in two other White Papers, *Promoting Better Health* (DoH 1987) and *Caring for People* (DoH 1989b) were to create the framework for a transformation of the NHS. *Promoting Better Health* was published after a long period of consultation following a government consultative document, *Primary Care: An agenda for discussion* (DHSS 1986b). The central aims of the proposals contained in the White Paper were the improvement in the standards of both health and health care, a greater emphasis to be put on health promotion and disease prevention as opposed to a service centred around the concept of treating existing disease, and the improved choice and information available to NHS patients. The strengthening of the primary health care system was to be achieved in part through changes imposed on the contracts of GPs and dentists.

Caring for People represents the government's response to the second Griffiths Report, *Community Care: Agenda for Action* (DoH 1988). Whilst the call for community care on humanitarian grounds had a long history (Ministry of Health 1954, Robb 1967, Martin 1984), it has also been suggested that an important driving force in the 1980s was the need to reduce public expenditure on health and social care (Baggott 1994). An emphasis was placed on the development of a pluralist system of provision utilising the voluntary and private sectors to a far greater extent than had previously been the case (Ham 1991a). A new system of funding was proposed which would remove the incentive to admit people to private and voluntary residential care, where they could receive a higher level of state support than if they had stayed

in their own homes. The proposed new funding system would not discriminate against those who stayed in their own home, for the level of state support would be the same in either circumstance. Despite the recognised benefits of non-institutional care, it was nevertheless difficult to visualise the community care component of the 1990 Act as driven by such altruistic motives:

‘They (the government) were not driven by a desire to improve the relations between the various statutory authorities, or to improve services for elderly people, or to help those emerging from mental hospital. They were driven by the need to stop the haemorrhage from the social security budget and to do so in a way that would minimise public outcry and not give additional resources to the local authorities themselves.’ (Lewis and Glennerster 1996 p 8)

Whilst community care is not the focus of this study, it is relevant to acknowledge its interplay with the changes implemented in the hospital sector. Community care policy brought implications for the work of NHS professionals practising within hospitals. Similarly the reduction in hospital beds discussed in Chapter 4 was to impact on those working in health and social care in the community.

The most radical of the government’s proposed reforms, and those with which this study is concerned, were contained in ‘Working for Patients’. Policy aims attempted both to overcome the problems which had beset the NHS, whilst at the same time be seen to be compatible with the government’s commitment to the belief in the market as being the best way in which to provide services, they had to allay the public fears which had increasingly developed, as there appeared a growing divergence between the public’s and the government’s views on health care provision (Cain 1988). The White Paper stressed that the founding principles of the NHS would be preserved and built on, and that the changes would be to the way in which the services were organised and delivered. The level of the government’s determination to forge ahead with these reforms is perhaps reflected in the decision to spend £1.4 million on the launch and publication of the document. Indeed it has been suggested that this demonstrated that they planned to leave nothing to chance in their plans for radical reformation (Levitt and Wall 1992). The exact nature of the proposals was identified

both in the White Paper itself, and also in the eight working papers which accompanied it (DoH 1989 c-j). Four main policy aims can be identified in these documents: the introduction of a new system of contractual funding; the development of measures to enable clinical activity to be managed more effectively; the presentation of new arrangements for the allocation of resources; and the strengthening of management at all levels.

At the very heart of the NHS Reforms was the notion that it should operate on a contractual basis, thus introducing the perceived benefits of the market system into the public service. It was proposed that this would be achieved through the development of an 'internal market' which would entail the separation of the purchasing of health care services from provision. It was planned that the Health Authorities would become responsible both for assessing the health needs of the population within their boundaries and the purchasing of health care services to meet those identified needs from a range of providers of health care. The relationship between the purchasers and the providers of hospital based health care services within the internal market was to be based on three types of agreements (Ham 1991a):

- (1) Contracts within the NHS, but in which there was no management relationship between purchaser and provider.
- (2) Management budgets which operated between a health authority hospital and its managing authority.
- (3) Private sector contracts in which the purchaser would contract for services with voluntary and independent providers.

Within these agreements there were to be three distinct types of contract (Ham 1991a):

- (1) Block contracts in which access to specified services is purchased, without specification of the exact number of cases to be treated.
- (2) Cost and volume contracts in which a price is agreed for a specified number of cases.
- (3) Cost per case contracts, in which a price is agreed for each individual case.

To facilitate the development of this internal market it was proposed that certain provider units could apply to become NHS Trusts which would allow them a more substantial degree of freedom and responsibility than in the managerial relationship with the Health Authority. In order to be eligible for NHS Hospital Trust status the hospital would have to prove that it was financially viable and would continue to be so for the foreseeable future. Becoming a Trust meant opting out of Health Authority control, and becoming directly accountable to the Health Secretary. Although still bound by the constraints set by government, those hospitals who acquired Trust status would also acquire freedom in several key areas:

- (1) The mix of staff and their pay levels could be determined locally.
- (2) Greater flexibility in managing assets, and utilising resources.
- (3) Whilst no 'profits' could be removed from the Trust, they could be used to improve facilities or services.

It was also planned that GP practices that had more than 11,000 patients registered could apply to become fundholders which would free them to make their own contracts with provider units to secure services for their patients. However, the extent of services for which the GP could contract were to be limited to certain standard treatments. Those GPs who became fundholders would receive their practice budgets directly, the amount being deducted from the Health Authority allocation, and these budgets would be calculated on the three main expenditures faced by GPs - hospital and other secondary care services, pharmaceuticals and practice staffing. Three key areas of autonomy would exist for those GPs who opted to become fundholders (Holliday 1995):

- (1) The freedom of budget flexibility between their three areas of main expenditure.
- (2) The choice to 'shop around' between hospitals in order to secure contracts on the most favourable terms.
- (3) The ability to carry forward savings from one financial year to the next, and whilst these savings could not be taken out of the practice as 'profit' by the GP they could be utilised to up-grade practice premises, or to provide education programmes for practice staff.

Several proposals aimed at the more effective management of clinical activity can be identified in the White Paper. The resource management programme introduced following the Griffiths Report (1983) was to be rapidly extended outside of the six pilot districts currently operating the system, and it was expected that all large acute hospitals would be part of the management resource programme by March 1992. It was also proposed to extend the range of information technology available to support GPs, and this included access to prescription analysis and cost data (PACT) which was viewed as a powerful tool for the monitoring and control of expenditure. A further strategy for managing clinical activity was through the extension of the programme of medical audit, both in hospital and primary care sector. An attempt to curtail the power of senior medical staff can be seen in the plans which related to greater involvement of general managers in the appointment of consultants, the agreement of consultant's job plans, and decisions relating to distinction awards. The commitment that it was proposed that consultants would show to the management of services was to be reflected in the inclusion of management criteria amongst the criteria used to determine distinction awards.

The proposals aimed to strengthen management at both central and local level, and in the new Department of Health a structural overhaul was to replace the Supervisory Board with a Policy Board, which would become responsible for the overall policy and strategy of the NHS, and a Management Executive in place of the Management Board which would take on the responsibility of implementing the policy and strategy decisions of the Policy Board. It was planned that at the local level the composition of both the Regional Health Authorities and the District Health Authorities would be reconstituted on more business-like lines and managers would sit on Health Authorities for the first time. Each Regional Health Authority would be regulated by a Board composed of chairman and five non-executive members appointed by the Secretary of State, one of whom must be the chairman of one of the Family Health Service Authorities within the Region; and five executive members to include the general manager and the finance officer. The District Health Authority was to be accountable to the Regional Health Authority which would be accountable for monitoring their performance. At this level the chairperson only was to be appointed

by the Secretary of State, and the Board would also include five non-executive members appointed by the Regional Health Authority, and five executive members who would again include the general manager and the finance officer. If the District Health Authority included within its area a teaching hospital, then one of the non-executive members would be selected from the medical school. At a primary care level the Family Practitioner Committees were to be replaced by the Family Health Service Authorities who again would be responsible to and monitored by the Regional Health Authority, which would also be required to appoint general managers who would sit alongside a chairman, five non-executive members and four non-executive members drawn from the health professions. It was argued that the creation of non-executive members would allow individuals to be appointed because of their personal qualities rather than because of the organizations that they represented.

The new arrangement for allocating resources can be seen to support the other proposals in the White Paper. All regions would, it was stated, by 1992/3 receive their main allocations on the basis of population, adjustments being made for age, morbidity and the relative costs of service provision. Arrangements for adjustments of cross-boundary flows would cease in 1990/1, to be replaced by direct payments to be agreed between regions. It was planned that districts would be funded on the same basis after a slightly longer period of transition. GPs who were eligible to become fundholders would have their budgets determined on the number of patients on their list weighted for age and other significant factors, structured to ensure that there would be no financial incentive to refuse to treat any particular category of patient. In exceptional circumstances adjustments to budgets could be made in respect of individual patients requiring especially costly treatment. A ceiling on hospital costs for any individual patient within one year was also planned, the excess costs to be met by the Health Authority. Regions would all receive, from central government, an annual block allocation to cover the cost of all prescriptions dispensed within their Family Practitioner Committees, and region would devolve this budget to the individual Family Practitioner Committees for allocation of indicative drug budgets to non-fundholding GP practices within their area. In an attempt to increase managerial awareness of the cost of capital, and to create the incentive to utilise

capital effectively it was proposed that capital charges would be introduced when budgets were being allocated. This was to be made up of two components, cost of depreciation of capital and interest on capital. Those provider units which applied to become NHS Trusts were required to take account of their capital assets, and to begin their corporate life as a Trust with an existing debt equivalent to those assets.

The programme set out in the White paper to implement the NHS reforms can be seen to fall into three distinct phases. The first phase of this staged implementation was planned for 1989/90, and there were eight clear aims to be achieved which would create the organisational environment for the creation of the internal market:

- (1) The NHS Policy Board would be set up.
- (2) The Management Board was to be reconstituted as the Management Executive.
- (3) The extension of the resource management programme would begin.
- (4) The review of the functions of Regional Health Authorities would begin with the planning for devolution of operational responsibilities to an individual unit level.
- (5) Regions would identify those acute hospitals which would become the first wave of self-governing NHS Trusts.
- (6) The first phase of the planned additional consultant posts would be created.
- (7) There would be an amendment of regulations which would render it easier for patients to change their GP.
- (8) The Audit Commission would begin work within the NHS.

The second phase of implementation of the Reforms, planned for the year 1990/91, demonstrated the accelerating pace of change with the seven key objectives planned:

- (1) The devolution of operational responsibilities to unit level would be completed.
- (2) The introduction of new management structures and financial and information systems into hospitals would be expedited.
- (3) 'Shadow' Boards for the first wave of NHS Hospital Trusts would be

set up and would begin to develop plans for the transition from Health Authority management.

- (4) Regions would be restructured to take over responsibilities from Family Practitioner Committees, and to oversee the establishment of the first NHS Hospital Trusts.
- (5) Districts would be restructured to take on the responsibility for the assessment of health care needs and the purchasing of health care services for their resident populations.
- (6) Family Practitioner Committees would be restructured with an emphasis on stronger executive management.
- (7) The new budget scheme for GP drug prescribing would be developed in preparation for full implementation in phase three.

The third phase of the implementation process which was to occur in 1991/2 would see the full impact of the proposals in the White Paper, with the achievement of two main objectives:

- (1) The establishment of the first wave of NHS Hospital Trusts.
- (2) The first of the GP fundholders would begin to exercise their new powers.

It was evident from this timetable of implementation that the government were going to press ahead with a rapid pace of change, and in effect the new NHS was going to be manifest almost immediately.

The philosophy underpinning the NHS Reforms

The proposals for the introduction of an internal market into the NHS can be seen to have developed from the ideas which had been generated by a number of analysts of health care systems (Enthoven 1985, Goldsmith and Willetts 1988). It was argued that the resulting competition between the providers of health care would lead to improved efficiency in both service and economic terms. Many of those who had been involved in the critical analysis of the NHS system of care, had looked to the health care systems of other countries to generate ideas about the ways in which the

existing service could be improved (Maxwell 1981, McLachlan and Maynard 1982, OECD 1987, Robinson 1988). Certainly Enthoven, in what was the first structured proposal for the functioning of an internal market, underpinned his ideas on his experience of the United States Health Maintenance Organisations, which base their delivery of health care on the basis of a set pre-payment rather than the more usual American system of a fee-for-service. It was Enthoven's concept which provided much of the impetus for the government's plans for the future of the NHS, aligning as it did with the prevailing political ideology:

HMOs are competing with each other to provide a quality product at a reasonable price. This is shown in the emphasis which they place on achieving consumer satisfaction; in the high quality of the information made available to prospective patients; in the accent on good management; and in the resources given to setting standards and to quality control. (DHSS 1986b p 55)

This adoption of American ideas may be considered with some amazement when taking into account that the USA was at that time attempting to deal, unsuccessfully, with the effects of a cost explosion in health care, the very thing feared by the British government, and not clearly related to the contemporaneous debate on underfunding:

This import of American ideas was, in many ways, surprising: it was very much a case of experts on obesity advising a patient suffering from anorexia. (Klein 1995 p 186)

However, what was evident was that Enthoven's belief in the power of the market model to improve both efficiency and quality harmonized with the government's view that public services should become more accountable for their actions. It should be recognised, and perhaps this could be argued to have been disregarded by the government, that this belief in the success of the American model was not universal, and when examining health care outcomes, significant problems were revealed. One analyst of the American system went as far as to call the competitive health care system in the USA as presenting: *'an opulent facade which masks the growing divide between the haves and the have-nots.'* (Rayner 1988 p 385). Other commentators supported the belief that a health care system run on the lines of a Health Maintenance Organisation would be likely to lead to a two tier system which would

lead to inequalities in care (Davies 1988b). The focus of the debate about the system of health care, in highlighting the way health care should be delivered, rather than the outcomes of health care, can be seen to have more to do with the prevailing political ideology than any other factor. It has been argued that the Prime Minister's review of the NHS was initiated through ideological commitment and transformed through the mediation of bureaucrats into something which was essentially unworkable (Paton 1992).

In the analysis of the values, beliefs and principles which underlie the differing systems of health care major differences can be identified. It has been suggested that these differences can be located on a continuum (Beauchamp 1976). At one end of the continuum can be positioned the values of public health justice and the principles which guide such a system are those of distribution of health care according to need, equality of access to health care services, a collective approach to public health problems and above all, humane, compassionate care within the system. At the opposite end of the continuum can be seen the values of market justice, and the principles which guide such a system are those of personal liberty, self-reliance, free enterprise and economic efficiency. It has been suggested that the proposals for change which followed the NHS review can be seen to represent a move away from the values of public health justice towards market justice (Caldwell and Francome 1993). Whilst the government attempted to allay anxieties by emphasising their commitment to the principles on which the NHS was founded, they perhaps underestimated professional and public commitment to the 'public service ethos' of the NHS. Although this ethos had perhaps been weakened in other areas of public service provision it appeared to be alive, well and kicking in the health service arena, and underpinned much of the confrontation which was to follow publication of the government's plans for reform.

It can be seen that this shift towards a market system of health care, albeit within a state funded service, was just part of the overall move towards a market led society, and compatible with the re-emergence of the political ideology of possessive individualism which was pursued by the New Right. Those who embraced this

political ideology argued that it was only the competition which would be engendered by the machinations of the market, that could lead to the necessary improvements to the NHS (Taylor-Gooby 1985). Yet it must be noted that some commentators have argued that the conditions which should exist for 'perfect competition' - homogeneity of service, plentiful producers and consumers with no collusion between them, a market price that is known with certainty, and external factors which are able to be accounted for - could never be achieved within the proposed internal market, and so the argument for such a market was essentially flawed (Prowle 1988).

Although the proposals for reform of the NHS were, in the main, structured on the work of Enthoven, his only claim to be on the right of the political spectrum is his firm belief in the competitive market as a positive driving force. In the United States, Enthoven is better known for his support for a fairer system of access to health care for the poor, and certainly in his reflections on the health care system of Britain, he was more concerned that workload was fairly rewarded rather than that competition be artificially generated to meet the needs of a market model of health care. In attempting to provide a political interpretation, the significance of the White Paper has been examined from a variety of perspectives. Some have put forward the view that it was merely a clever exercise to divert public attention from what, it was argued, was a chronic underfunding of the NHS (BMA 1988, 1989), whilst others have considered the possibility that the Reforms were signs of the political machinations aimed at disbanding the concept of a nationalised health service (NHS Support Federation, NHS Consultants Association 1991), and thus view it as being more related to political ideology than to an attempt to improve the health care system. This viewpoint has been supported by those who suggest that competition cannot be regarded as the primary agent for reduction in costs or improvement in efficiency (Francome 1992). Also highlighted has been that the cost of managing the NHS at the time of the Prime Minister's review, was significantly less than the cost of managing the health care systems in other countries (Timmins 1988, Francome 1992). It could be suggested therefore, that the review with its strong emphasis on creating more effective management, failed to appreciate the strengths of the existing system; and that the proposals, in turn, failed to build on these strengths. The review

of the NHS and the subsequent White Paper were far from being unanimously accepted as being aimed at improving the existing health care service. Although the stated aims of the review team focused on the enhancement of services within the NHS, the proposals which were put forward could be seen not only to further the political goals of the government, but also to create a service environment which was more in line with the prevailing political ideology.

The response to the White Paper proposals

The initial response to the government's proposals were, in the main, extremely negative, although a significant portion of the medical establishment supported the proposals wholeheartedly. Those who did support the proposed changes aligned themselves with the government's argument that the proposed changes would result in better value for money by a more efficient use of available health care resources. This improved cost effectiveness was believed to be achievable through the introduction of free market principles of consumer sovereignty into the NHS which would, in itself, lead to increased consumer choice as services diversified (Fordham and Newham 1989). Other members of the medical profession however, abhorred this talk of 'trade' in relation to medical services, and took the view that such market changes would inevitably lead to a deterioration in the quality of NHS services. Doubts were expressed both by health care professionals and policy analysts that, disregarding any foreseeable problems, the Reforms could ever hope to achieve the stated aims of the White Paper. It was argued that the proposals, if implemented as they stood, would restrict rather than enhance patient choice, and that the development of a highly managed market would inevitably disadvantage some patients (CHE 1990, Nixon 1990). Some doctors pointed out that as the White Paper proposals transferred responsibility for obtaining or providing services onto the shoulders of GPs, at the same time it could be argued to be absolving central government from such responsibility, and it was suggested that this move would ensure that any further public outcry about underfunding could be focused away from the government (Harris 1989). It was highlighted that the year 1989/90 was one in which a number of health authorities had accrued a significant overspend, and the issues relating to underfunding had become increasingly prominent on the opposition

agenda (Appleby 1990). A survey which had been carried out in March 1990 revealed that over 83% (of a 68% sample) of Health Authorities believed that 1989/90 would prove to be a difficult or very difficult year financially, and that just under 40% of the respondents expected to experience problems relating to the implementation of the White Paper proposals (NAHA 1990).

Also questioned was the way in which it would be possible to evaluate the effect of implementing the NHS Reforms in certain areas. It was pointed out that if the criteria in relation to drug expenditure was to be one of improved cost effectiveness, then the monitoring of this alone would be meaningless, but that it would be virtually impossible to collect the data which related to the quality of care and treatment outcomes on a scale great enough to evaluate the success or failure of the changes (O'Brien 1989). It increasingly became a matter of professional debate whether economic criteria could, or should, be aligned to the outcomes of health care delivery, and if so could this prove to be an effective way of evaluating the NHS Reforms. However, decisions relating to the way in which the changes could be evaluated remained largely absent from the government's deliberations.

The opposition to the proposals continued unabated in the months that were to follow publication of the White Paper. There was a general consensus outside political circles that the proposed timetable for implementation of the Reforms was all but impossible to achieve, and serious concern developed over the failure to allow time for demonstration projects or for evaluation for those projects, such as the resource management programme, which were already underway. Many doctors took the view that the government's insistence on such a rapid pace of Reform was unnecessarily abrasive and confrontational. Enthoven, whose ideas had influenced many of the ideas reflected in the White Paper had also admitted to concerns about the pace of implementation, admitting that he was *'troubled and concerned (at both) the speed and the manner'* with which the government was planning to implement the proposals. He was particularly uneasy over the lack of pilot projects which could have been used to evaluate the scheme before it was implemented nationwide (May 1989 p 1150). In fact the speed with which the government was pushing forward

with the implementation of the proposed changes was something which was causing anxiety to many. The government was accused of pre-empting legislation by forging ahead with the recommendations of the White Paper before they had been debated in parliament (Millar 1989b). Despite Professor Harry Keen's attempt to stop this 'jumping the gun' on implementing the Reforms, money continued to be spent prior to the passage of necessary legislation. Judges failed to support Professor Keen's challenge, basing their judgement on the interpretation of a section of the 1977 National Health Service Act. The vagueness of many of the proposals was another area which was heavily criticised, and the apparent inability of the Department of Health to provide clarification did not encourage the belief that the consequences of such proposals had been carefully anticipated and approved. In many respects the White Paper was viewed as being more of a political statement than a planning document (Butler 1989). Many GPs were vehemently opposed to the proposed NHS Reforms, and national representatives of GPs condemned the NHS review as ignoring the critical matter of the level of funding, which in itself was argued to endanger the comprehensive nature of the health service, adversely affecting the quality of patient care and almost inevitably destined to result in the development of a two tier health care system (MacPherson 1989).

The formal response of the medical profession to the White Paper was not made until May 1989, and despite the earlier outcry against the Reforms, was not entirely negative. At a special representative meeting of the BMA, the medical establishment endorsed several aims of the White Paper:

- (1) Needs of patients should be paramount.
- (2) The NHS should be available to all, regardless of income, and funded mainly from general taxation.
- (3) Patient choice should be extended.
- (4) Those who provide the service should be responsible for day-to-day decisions about operational matters.
- (5) Health Authorities should ensure that the health needs of the population are met and that efficient services for preventing and controlling disease and promoting health should exist.

In many ways the response of nurses to the White Paper reflected that of the doctors in that there was a general condemnation, and this led to the suggestion that the government was intent on implementing the proposals in the face of unanimous opposition, natural justice and common sense, and the implication was made that the principles on which the proposals were made were inhumane, and the content of the proposals was unworkable (Gooch 1989). There was also criticism that the White Paper in outlining the face of the new style NHS failed to clarify the role of nurses within the transformed system, and it was in fact left to the Nursing Division of the Department of Health to issue a paper to clarify and complement the White Paper (DoH 1989). Although generally there was agreement from the profession about the government's view of the way forward for nursing, many dismissed the paper as being idealistic, and almost certainly unachievable in the prevailing politico-economic climate (Turner 1989). It must also be noted that there was evidence of an increasing marginalisation of nurses from the policy process, and serious disquiet was expressed about decisions regarding the future of the NHS being made without any reference to the largest professional group, when the NHS Policy Board was structured without a nurse on the Board (Naish 1989). At the Royal College of Nursing Congress in May 1989, Congress was issued a mandate to launch a campaign to protect the NHS in the light of the Proposals for change. The RCN found little to praise in the vision for a new NHS, attacked government for failing to address the nation's true health needs, and stated its belief that the recommendations if fully implemented would force a growth in both administrative and medical costs. It was also suggested that the proposals threatened both the principles and effectiveness of the NHS.

This concerted opposition to the government's plans for the NHS was one which, not surprisingly, drew the attention of Kenneth Clarke the Minister of Health, and in an interview he announced that to win over the hearts and minds of the NHS staff : *'to revolutionize the culture as well as the framework (was the) single most important thing'* in relation to the realisation of the proposals (Moore 1989 p 1300 - 1301). It was also around this time that patient and consumer organizations began to step up their campaign against the proposed NHS Reforms (Gaze 1989), and opposition could then be seen to be attacking the government from all sides. However, there was

never any evidence to suggest that the government viewed such opposition as anything other than a reaction to proposed change, combined with a lack of understanding, rather than a genuine conflict of values, beliefs and ideas. In response to a question in the House, Kenneth Clarke revealed that he had received more than 2,000 representations on the White Paper proposals, expressing a wide range of views. He also added that he regretted that a proportion of these opinions were based on inaccuracies, one source of which he cited as being the BMA, the other, the Labour party (Hansard 1989). It was reported, however, that not only did Kenneth Clarke have to deal with opposition from health care professionals and health services users, but he also had to fend off attacks on the proposed changes from fellow Conservatives (Davies 1990). Many MPs who held a slim majority were seriously worried about the political wisdom of what was perceived by many of the electorate to be an attack on the NHS.

The issue of spending on the implementation of the Reforms prior to their debate in parliament, was one which continued to be the subject of much attention from many opponents of the Reforms. Special concern was expressed about the funding and development of the information technology which was a pre-requisite of the Reforms. Although the government gave a cash injection of £134 million, after spending on resource management and medical audit, only £25 million remained to be spent on general hospital information technology and support systems. The true cost of the complete information technology system had been estimated at £101.8 million in capital expenditure and a further £35.3 million yearly in revenue costs. It was alleged that this level of spending could neither be achieved nor sustained without cuts to direct patient services (McFarlane 1990). In the House of Lords Baroness Hooper admitted that funding in 1990/1 for the NHS Reforms was expected to be £300 million (Hansard 1990a). It was also established, in response to a question posed in the House of Commons, that the cost of a booklet explaining the Reforms had been £2.2 million, with an additional £2.75 million set aside for copies to be produced in minority languages (Hansard 1990b). In addition, it was revealed that, by 1993, the Department of Health's press office employed fifteen staff (Hansard 1993a). Both health care professionals and users of health care services challenged this use of

public money for government publicity, but to little avail.

One year after the publication of the White Paper, health service managers and clinicians continued to express their concerns that so many questions remained unanswered (Adam and Beck 1990), and it was around this time that reports began to surface of patients being struck off GPs lists for being over-demanding or financially unviable (Glasman 1990). Commentators began to suggest that this would become more commonplace as GPs began to 'prune' their lists in preparation for achieving fundholding status. Yet despite the enduring opposition and the problems that were already beginning to emerge, the 1990 NHS and Community Care Act travelled virtually unscathed through the legislative process, and the recommendations contained within the White Paper became enshrined in statutory law. However, there was some evidence that as William Waldegrave replaced Kenneth Clarke at the Department of Health, and John Major replaced Margaret Thatcher as Prime Minister, so there began to be seen a small but significant deceleration in the pace of the NHS Reforms as the timetable for full implementation was extended (Ham 1991b).

The effects of the NHS Reforms

On April 1st 1991, the recommendations for the reform of the NHS contained in the White Paper were implemented, and the impact of these changes was soon to become apparent. Whilst the administrative changes were massive, and the impact almost instantaneous, the impact on the actual delivery of services was slower to reveal itself. Whilst the managerial and professional staff within the NHS experienced great change in the way in which they worked, for patients, at least in the early stages, there was little real evidence of change, and so to an extent, public fears about the new situation may have been temporarily allayed. However, despite the government's desire to depoliticise the issue of health care, it has remained prominent on both the political and the public agenda, and looks destined to continue to do so, and debate continued to be fierce in support or opposition of the NHS Reforms, as individuals and organisations attempted to assess the effects of the changes as they occurred. However, there was little, if any, consensus on the nature of the effects of the

Reforms, and to a great extent they were viewed from the prior perspective of the observer according to whether they supported or opposed the Reforms. Whilst the supporters of the new regime praised the improvements which they viewed as being a direct result of the Reforms, so those who opposed the changes tended to focus on the perceived deterioration of the service, which they too viewed as a direct effect of the Reforms. Benefits were discussed in terms of improvements in the quantity of health care delivered and an increase in the awareness of quality issues, whilst disadvantages were discussed in terms of worsening inequalities in health care and increasing bureaucratisation. Although some GPs supported the Reforms wholeheartedly, and approved of the improved services that they had been able to secure for their patients (Johansson 1991), others argued that the improvements enjoyed by some patients were only achieved to the detriment of services to others, and that the result of this was that a two tier system was emerging (Lewis 1991). As early as six weeks into the new financial year concern was being expressed over anticipated redundancies in NHS Trust Hospitals, and the consequent reduction in support services. It was claimed that this led to an increase of non-clinical duties for junior medical staff (Ind et al 1991). Yet despite these reported redundancies in the early days of the new system, it soon became apparent that the increasing administrative workload generated by the Reforms necessitated an increase in those staff employed to carry out administrative duties. In response to a question in the House of Commons Virginia Bottomley the Health Secretary revealed that in September 1990 15.1% of the NHS workforce was made up of those in administrative grades which represents an increase from 13.3% in September 1979 (Hansard 1992a). It also emerged that the number of nurses and midwives employed in the NHS fell from 395,360 in September 1990 to 392,000 in September 1991. In the same period of time administrative and clerical staff numbers rose from 120,040 to 127,370, and the number of general and senior managers rose from 9,680 to 13,340 (Hansard 1993b).

Whilst one of the major aims of the NHS Reforms was to improve patient choice, claims soon began to be made that this was not happening, and particular attention was paid to the issue of extra-contractual referrals, whereby patients could be treated

on an individual basis at a hospital with which the GP or Health Authority did not have a contract, but who would agree to meet the costs. One study concluded that the management of extra-contractual requests was both complex and time consuming for clinicians and managers alike. Patient choice was clearly being limited to some extent, but this may well have been necessary if the number of requests was not to exceed the levels at which funding was based (Williamson 1991). Another study drew similar conclusions, that the price for a relatively limited choice for GPs and patients was a '*considerable administrative workload*' (Ghodse and Rawuf 1991 p 409). Various hospitals obviously had different experiences in the early days of the Reforms, and it was reported that there was evidence that some hospitals were demonstrating a growing sensitivity to patient focused care as opposed to service focused care, despite worrying financial problems (Laurance 1991). Other hospitals were reporting that whilst progress in service development was virtually nil, activity was frenetic (Delamothe 1991). As the different provider units began to experience the reality of being in a competitive relationship with others, so disquiet began to be expressed about the development of what appeared to be a climate of confidentiality sweeping the NHS Trusts, and confidentiality clauses began to be included in staff contracts. For not only were the Trusts keen to protect their business plans from rivals, but they also became increasingly aware of the damage that any evidence of failure in service provision could inflict on their bargaining power. This issue was one which received much adverse publicity in the media and prompted questions in the House. In May 1992 the Health Minister Dr Brian Mawhinney denied that confidentiality clauses in staff contracts set out to inhibit professionals from expressing their opinions, stating that they were aimed at safeguarding sensitive data (Hansard 1992b).

It became obvious that despite massive injections of cash into the provision of sophisticated information technology systems there were widespread problems relating to the management of financial contracts and workloads. Further delays to the move towards basing health spending on population size had become evident by the end of 1991, as it became apparent that the reductions in allocations which would occur as a result of this would inevitably force some hospitals to close (Sheldon 1991b). It

was also reported that:

Massive discrepancies in the estimates of capital charges.....have forced the Department of Health effectively to write off the first year as a paper exercise.

(Moore 1991 p 3)

As projections about the level of expected overspends began to be expressed, so could a growing number of provider units be seen to develop a range of strategies for income generation. These ranged from the sale of high technology diagnostic services to the private sector, to pay-roll processing for the growing number of multi-agency consortia that were being established (Pollard 1991), whilst other more contentious ideas such as the introduction of car park charges for staff, patients and visitors, also became commonplace.

A concern began to emerge at the end of 1991 about the way in which activity within provider units continued to rise despite the fact that these provider units were likely to reach their contract targets ahead of time. Some health policy analysts argued that this inability of the internal market to control demand by prioritising and rationing was due to a basic flaw in the logic on which the internal market was based (Salter 1991). Other commentators suggested that prioritisation of services was approached in a somewhat haphazard manner, and in many instances could be seen to be reactive rather than proactive. The Kings Fund Institute worked to clarify the task of prioritisation and concluded that Health Authorities needed to take account of four major inputs as part of the decision making process - top-down priorities, bottom-up consultation, professional opinion and research-based evidence (Robinson 1993). Questions began to be asked about the limits of the NHS responsibilities for the provision of free health care, and cases were made public in which it was difficult to determine who would finance the care required (Davies 1991). The issue of lengthening waiting lists was one which occupied both the politicians and the public during the first years of the Reforms. One report highlighted the notion of waiting lists as an approach to rationing health care resources, and compared this approach to others such as rationing by delay, dilution, deterrence, ignorance or termination (Ruddle 1991). It has been argued that whilst waiting lists, or at least lengthening waiting lists, might be neither politically nor publicly acceptable, the alternatives may

be even less so (Higgins 1991). A study of the 1992/3 purchasing plans revealed that Health Authorities appeared to be very reluctant to be seen to be rationing resources, and were attempting to deal with the problem of insufficient resources to meet the totality of health care demand by spreading their money around ever more thinly (Klein and Redmayne 1992). However, it was suggested that the reduction of resources allocated to some Health Authorities which would follow the implementation of plans to move towards allocation by weighted capitation, would almost certainly push them into making some attempts to ration health care services in 1993/4 (Redmayne 1992). As the debate about rationing became more overt some commentators emphasised the benefits of health care rationing in terms of the availability of additional health care resources for priority services. Suggestions for rationing have included the exclusion of non-medical conditions, unproven treatments, expensive procedures with no demonstrable advantages, and self-inflicted injuries (Byrne 1992). Some Health Authorities have made overt decisions about which services would be funded, and which would not, and some of these decisions have drawn media attention, but it is likely that in many cases such decisions remain concealed, and not subject to open debate (Klein 1995). Although, in theory, the system of purchasing and providing within the internal market should have brought priority setting and subsequent rationing decisions into the open, in reality this has not happened, and such decisions remain behind closed doors (Redmayne, Klein and Day 1993).

The first report of the Commons Health Select Committee (CHSC 1991) reflected the government's commitment to maintain the waiting list initiative, at least until it became evident that the Reforms, in themselves, were capable of replacing the waiting list initiative in reducing waiting times. Although both financial and managerial resources were diverted towards bringing down waiting times, the effectiveness of this was challenged. Although government statistics appeared to suggest that the waiting list initiative was succeeding, doubts were expressed about the veracity of such statistics. In response to a question in the House, Virginia Bottomley stated that more than 10% of patients were removed from waiting lists without receiving their treatment between September 1990 and March 1991. Whilst

during this time 1.38 million patients left the waiting list following treatment, 168,000 were removed from the waiting list without having been admitted for the treatment for which they were waiting (Hansard 1992c), and this led to the claim being made that the improvements claimed by the government to have been achieved by the Reforms, were in reality no more than the massaging of statistics. This was not the only time that government statistics were seen to be reflecting a rather optimistic view of the Reforms in terms of patient outcomes. Whilst it was stated that in 1991/2, 500,000 more patients were treated than in the previous year, representing an increase of 7%, this was hotly disputed. It was argued that the new method of recording health care service data was responsible for this apparent improvement. It was claimed that the way of measuring patient treatments - the Finished Consultant Episode (FCE) - was both inaccurate and misleading. It was pointed out that transferring patients between consultants during any one period of hospital treatment, a not uncommon occurrence, now appeared as two or even more, FCEs whereas as before it would have been recorded as one episode of treatment, and this change would indicate increased activity without any real increase in patient throughput (Clarke and McKee 1992, Seng, Lessof and McKee 1993). As attempts to evaluate the effects of the Reforms continue, so does the inadequacy of available health service data become more apparent. The simplistic measures which are accessible do not depict the complexity of health care provision, and may, in fact, obscure that which would enable judgements about the success or failure of the Reforms to be made. Even to examine a relatively straightforward measure, that of health service activity, is problematic, for whilst at first sight it would appear that activity has continued to rise each year, day cases have almost doubled whilst in-patient hospital admissions have almost halved (DoH and OPCS 1994 Table 18).

What was unarguable was that the Reforms, whatever their effect, had revolutionized health care organisation and the extent of the transformation can be seen in several key areas:

- (1) The number of GP fundholders has risen from 306 in 1991, when 7% of the population was registered with a GP who was a fundholder, to 10,410 in 1995 when 42 % of the population were on the list of a GP

fundholder. Increasingly smaller GP practices were encouraged to become fundholders as the number of patients at which GPs were eligible to become fundholders fell from 11,000 in 1991 to 9,000 in 1992, to 7,000 in 1993 and finally to 5,000 in 1995.

- (2) In 1991 57 of the 66 hospitals which had applied became NHS Hospital Trusts, in 1995 98% of all acute hospitals were NHS Hospital Trusts, and by 1996 it was envisaged that no acute hospitals would remain as units directly managed by the Health Authority.
- (3) The complexity of Trust applications increased, and whilst the first wave of NHS Trusts were confined to acute hospitals, since then different forms have emerged, as district wide providers have developed, as well as combined community and hospital providers. Specialist hospitals and ambulance services have also become NHS Trusts.
- (4) Waiting lists have continued to rise, exceeding 1 million for the first time in 1994, but waiting times have fallen sharply.

When considering the NHS Reforms implemented in 1991, it becomes apparent that frequently the commentators strongly held views concerning the nature and provision of health care services to some extent lead to a subjective rather than objective evaluation of both the process and outcomes of the most radical remodelling that the NHS had experienced in its history. To distinguish rhetoric from reality is often difficult in a situation where there appears to be little common ground or even, it could be suggested, little common language, between those who support and those who oppose, and there is no evidence of any consensus as to what criteria should be used to evaluate either the efficiency or effectiveness of health care services. The evaluation of such a complex policy change cannot be achieved in a simplistic way, nor can the process of change be divorced from the outcomes, and in the final analysis, as health care is something which is not only delivered in quantitative terms, but also experienced in a qualitative way by patients, the quality of the individual experience needs to be evaluated alongside the measure of health care services purchased and provided within the transformed health care system. Whilst the aims

of health service reforms focused on improvements for the patient, who was linguistically transformed into a consumer in the new style NHS, little attempt has been made to evaluate the effect of the Reforms on the quality of health care services available to and accessed by the patient, indeed it could be argued that little attempt has even been made to determine the nature of health care quality. Although the internal market has been integrated into the NHS, and the language of the market has entered into professional discourse, the patient has never accrued the power of the true consumer to bestow or withdraw custom as a response to the quality of service delivered, or to influence the determination of quality standards.

CHAPTER 6

THE QUALITY OF CARE IN THE NHS

Problems in determining health care quality

Although the pursuit of quality improvement and quality assurance has been a key feature of both service and manufacturing industries since the 1950s, the introduction of a focus on quality into the NHS was, in comparison, relatively late. Enthoven (1985), the guru of the NHS Reforms highlighted the lack of a quality drive during his early deliberations when he pointed out that, whilst the NHS ran on the ability and education of its workers, its structure contained no incentives to improve quality at a reduced cost. As in other welfare services the focus was on provision rather than receipt of services for many years, and the need to attract, satisfy and retain customers did not arise as an issue. However, as the patient of the NHS was transformed during the latter half of the 1980s into the customer of the health care provider, so the issue of quality of care became more prominent on the managerial and professional agenda. Whilst this does not indicate that those engaged in the delivery of health care services were unaware of quality, it does perhaps signify that there existed a somewhat subjective, unstructured notion of quality which had largely remained unarticulated, and this may go some way to explaining the difficulties that have arisen in relation to determining the nature of health care quality. These problems are at the same time philosophical, political and practical, and until the difficulties can be resolved, it is difficult to see how any consensus over either the recognition or the pursuit of quality within the NHS can advance. At the same time this lack of consensus adds to the difficulties of evaluating the impact of change within the NHS, in relation to the quality of care.

Philosophical difficulties in determining health care quality

From a philosophical perspective, it has been identified that the understanding of the term quality differs from within and outside the NHS (Seedhouse 1994). The gradual evolution of a definition of quality within the NHS, which may well not be recognised

outside of the organisation, has negated many of the benefits which can undoubtedly be obtained from focusing on the attainment of quality in service delivery. Whereas in organisations outside the NHS the customer is viewed as 'king', within the NHS the patient's position is less clear cut. Within the post-Reforms NHS the split established between purchasers and providers in the creation of the internal market has resulted in a split between 'purchaser' and 'consumer', a quasi-market feature that cannot exist within the commercial market. There is a fundamental problem in adopting any quality framework devised for the commercial market, into a quasi-market organisation, as the struggle emerges to ascertain whether the needs of both purchasers and consumers can be met by the provider. As purchasers, Health Authorities and GPs inevitably utilise different criteria for determining the quality of health care than do patients - the users or customers of the service - so in a real sense the NHS is required to attempt to reconcile these differing criteria in the attempt to deliver a quality service:

The significance of the separation of the users and the customers of the NHS is that quality can be perceived in many different ways. To provide an example of the kinds of positions that might be adopted, we can imagine providers to whom quality could mean 'providing the best possible solution for each client, no matter what', purchasers to whom it could mean 'meeting specification' at the lowest possible price; and users to whom it could mean 'having the largest amount of choice in health care options, regardless of cost. (Gregory and Walsh 1993 p 173).

Obviously, it can become difficult both to identify differing perceptions of quality, and also to meet the quality requirements of the key players in the provision of health care services -the purchaser, the provider and the user. An issue which is likely to engender increasing debate is the purchaser's involvement in the quality process because of their input to clinical audit. The Department of Health has directed provider units to incorporate purchasers' views into the further development of multi-disciplinary audit (DoH 1993a, DoH 1993b), and funds for audit have been allocated to purchasers, which will inevitably lead to them exerting greater influence on both the development of clinical audit and the content of such audit schemes. A recent study revealed that there existed important differences in attitudes and expectations

in relation to clinical audit, between the purchasers and the providers (Thomson, Elcoat and Pugh 1996), and these differences are likely to express themselves in both the definition of quality, and the processes adopted to monitor the quality of health care provision:

Quality.....is a highly personalised concept and the important message for health and care services is to begin to ask questions about whose quality ought to be controlled or appraised (Phillips, Palfrey and Thomas 1994 p 17)

Another study that compared the criteria of patients with the criteria of government for evaluating GP services revealed very few similarities, which led the researchers to argue that there appear to be limits to both consumer sovereignty and professional authority in good practice (Smith and Armstrong 1989).

A further reason why quality is such a contentious issue, within the NHS, and so difficult to conform to a commercial quality framework is that determining the quality of health care is a fundamentally different problem from that of determining the quality of a product. Whilst the quality of a product such as a car may be measured by assessing its performance in a given range of areas, the measurement of the quality of health care can be seen as much more subjective, and the desired outcomes for patients of the NHS are likely to be considerably more diverse than the desired outcomes of the purchasers of cars. Although many who use health care services will aspire to the eventual return of full health, it has to be recognised that, for many, this is not an achievable goal, and even if it were, the construction of viable outcome measures for this would necessarily be subjective, as health is a concept which is difficult to define in measurable terms. For those individuals who are unlikely to return to what they perceive as full health, the problem of determining health care quality is most marked, for the assumption cannot be made that the only benefit of health care is an improvement in health status, and a range of sources of benefit need to be recognised in order to capture the quality of health care services (Ryan and Shackley 1995). Such benefits may include comfort, reassurance, information, and autonomy as well as other non-medical benefits such as access to alternative means of support. The important issue which arises in identifying the variety of sources of benefit gained from receipt of health care services is that it can only be the direct

consumer who can determine the comparative importance of these various sources of benefit, because it is only the individual in receipt of health care who can evaluate the effect of the received health care on their utility or wellbeing. This question of subjective quality evaluation highlights the difficulties which occur when trying to adopt the commercial definition of quality to act as a framework for evaluating care. However, any attempt to redefine the notion of quality needs to incorporate open debate in order to be able to achieve a consensus over the nature of quality within health care. Nevertheless, this is a debate which has largely taken place behind closed doors, and thus the philosophical foundation of the concept of quality within the NHS is at best unclear, and at worst manipulative.

Political perspectives in determining health care quality

Examining health care quality within a political framework is an issue which has been at the forefront of policy developments in recent years, and a key aim in the implementation of the NHS Reforms, however it has been highlighted that there has been a significant lack of appreciation for the complex area of quality assurance in the NHS (McClachlen 1976, 1990). It is not the case that quality had been an issue which was neglected or disregarded, but that it had remained largely unarticulated in comparison with the commercial sector.

From the political perspective health care quality has taken on a very specific meaning, and is largely viewed as 'value for money', and as there is general agreement that the measurement of health care outcomes is an area which remains underdeveloped quality measurements have been, to date, related to efficiency rather than effectiveness. Although there is a drive to develop appropriate measures for health care outcomes which could be used to determine the benefit accrued from health care intervention in terms of health status, the current lack of consensus over the definition of quality in relation to health care has led to the adoption of certain performance indicators as measures of service quality, at least within the political arena. The level of activity has been a traditional measure of NHS performance, and prior to the NHS Reforms the level of activity was evaluated in relation to the length of waiting lists, the underlying belief being that any failure in performance would

reveal itself in lengthening of the waiting lists, hardly a sensitive measure as waiting lists have continued to increase since centralised record keeping was established. However, since the NHS Reforms, this traditional benchmark of performance has been replaced by a focus on the length of wait, rather than the length of lists. It is argued that it is irrelevant how many people are on the waiting list, what matters is how long those on the list have to wait for their treatment. However, this change is not without its problems, and whilst the data is easily accessible it is neither reliable as a quality measure, nor easy to interpret (Frostick, Radford and Wallace 1993). Whilst waiting times may provide evidence on which the government may claim success in the implementation of the NHS Reforms there are three main difficulties which arise in utilising waiting times as a measure of NHS quality (Sheldon 1994):

- (1) There is a fundamental problem in that it is impossible to distinguish between inefficiency and excess legitimate demand. A serious epidemic would result in an inevitable increase in waiting times, yet it would obviously be wrong to interpret this as a sign of inefficiency, which highlights the limitations of waiting times as an appropriate efficiency measure.
- (2) A difficulty also arises in the inability to consider the relative benefits to different client groups, and so in order to avoid the claim of inefficiency it would appear to be appropriate to prioritise the needs of those who have been waiting longest over those who may have greater clinical need of health care services. Conversely, a more acceptable view of efficiency would accord higher priority to patient need than to waiting time.
- (3) To use waiting times as a benchmark of quality performance opens up the possibility for the production of a range of unintended consequences which could result from manipulation of the data by health care service providers, and attempts to play the system by both service providers and users. Indeed, there appears to be much anecdotal, but little objective evidence that some of the waiting list management strategies are aimed at massaging the statistics on which they will be judged (Dean 1991).

Practical issues in determining health care quality

From a practical perspective, determining quality in health care is complex, and whilst clinical audit is well established, and patient satisfaction surveys commonplace, there remains little, if any, consensus as to the nature of what is being measured by such programmes. Although the importance of the views of patients on the quality of health care services has been well recognised, the incorporation of their views into service planning has remained problematic. For over three decades attempts have been made to obtain patients' views about their medical and nursing care (McGhee 1961, Cartwright 1964). Although two national studies have been carried out (Raphael 1977, Gregory 1978) most studies have remained on a local scale since then, and much of the work in relation to service provider surveys of patient satisfaction remains unpublished. What is significant in such work, is that the one issue which consistently emerges as being viewed as unsatisfactory is the area of communication between NHS staff and patients. This can be seen to illustrate the importance which patients place on the one to one interaction between themselves and the health care professionals, and which, it could be argued, is an area which is poorly reflected in the existing quality measures in the NHS. The ways in which such process oriented measures could be developed, however, remains unclear, and marginalised in the current drive towards evidence based medicine and health status outcome measures. Despite the introduction of a broad spectrum of quality initiatives in the NHS, quality is not a concept which has a shared meaning between, and even within, groups of health care staff, and a survey has revealed that there is inconsistency in the way that quality related terms are utilised (Dalley 1989). It can be seen, therefore, that from the practical perspective difficulties arise in two main areas, firstly in determining what it is that needs to be measured and developing appropriate measures, and secondly, in accessing the required information.

Quality in the NHS

Amongst professional staff there was a fear that the focus on quality would develop into a preoccupation with cost effectiveness at the expense of the traditional concern with the quality of care (Redfern and Norman 1990). There was a degree of

consensus in the recognition that the wholesale adoption of a commercial framework for quality was inappropriate, and that quality within the health care context had to be greater than a consequence of consumer satisfaction, but needed also to incorporate concepts such as those of access, equity, acceptability, efficiency, effectiveness and appropriateness (Maxwell 1984, Shaw 1986).

In relation to the difficulties which exist in defining health care quality, it has been suggested that two essential components need to be recognised (Donabedian 1980). The first of these is the technical element, which relates to how health care science and technology are applied with the aim of maximising patient benefit without any corresponding increased risk to the patient's health. The second component identified by Donabedian relates to the interpersonal aspect of health care, and involves the management of the psycho-social interaction between patient and health care professional in a manner which meets socially defined values and norms.

Bank (1992) has identified twelve core concepts of quality management, some of which have been incorporated into the NHS quality framework, but others of which are noticeably absent:

- (1) Quality for profit, efficiency and the elimination of waste within an organization. This has indeed been a major focus of the NHS quality drive, and very often the driving motivational force behind the introduction of quality assurance programmes into NHS units.
- (2) The 'Right First Time' concept, which focuses on preventing problems before they have a chance to occur. It could be argued that the NHS works more on a concept of 'Right Most Times' as the idea of foreseeing and eliminating all problems from what is, at best, an imprecise science, appears to daunt even the most ardent supporters and promoters of quality health care services.
- (3) The notion of a 'Zero Defect' product or service, by eliminating the idea of an acceptable failure rate. It is noticeable that the quality standards commonly set within the NHS include an accepted failure rate, albeit often significantly lower than perhaps had been achieved

prior to the introduction of the quality standard. However, Bank highlights the fact that even if the acceptable quality level is 99%, then there could be at least 200,000 wrongly issued prescriptions each year.

(4) Recognition of the costs involved in the drive to improve quality within an organization related to:

- (a) Prevention of problems
- (b) Appraisal schemes
- (c) Internal and external failure
- (d) Exceeding the level of required service
- (e) Lost opportunities

This is an area which has been accorded a relatively low profile in the NHS, as with such a major focus on cost containment, there has been little evidence that the necessary costs of quality have been recognised, calculated or budgeted for (Joss and Kogan 1995). Although programmes such as appraisal schemes have been almost universally introduced there is little to suggest that inclusion of these quality costs as a universal feature of NHS budgets:

The trade off between quality and cost should not be avoided but rather confronted at an early stage. Many quality improvements may be available at low or no cost, but this should be shown by careful analysis, not assumed. (Pollitt 1996 p 108)

(5) The idea of competitive benchmarking introduced as part of the drive towards the attempt to be better than the best competitor. The publishing of hospital 'league tables' can be seen to provide such benchmarks by which individual provider units can be compared, and thus may be argued to promote competition between NHS provider units. However the value of issuing such tables has been hotly disputed both from within and outside of the NHS. Several problems have been identified with the attempts to introduce benchmarking into the NHS (Pollitt 1996):

- (a) Inappropriate processes may be chosen to benchmark

- (b) When monitoring has revealed room for improvement, there may be a failure to implement change.
 - (c) There have been occasions when inadequate time, resources and support have been invested by senior management.
 - (d) Attempts may have been made to benchmark too many processes at once.
 - (e) Data may prove to be inaccurate or meaningless.
- (6) The involvement of all staff in the drive for quality. Although many quality assurance programmes in the NHS may be seen to be driven from the top, there has also been the development of a wide range of quality initiatives, and schemes such as Quality Circles and Quality Improvement Drives (QUIDS) have aimed to involve staff at all levels of the organization.
 - (7) The move towards facilitation of synergy in teamwork. Within the NHS reorganization of the management structure below Board level, the subsequent introduction of clinical directorates and practice management teams, has been viewed as a mechanism by which quality may be improved through more effective teamwork.
 - (8) The cultivation of a sense of ownership, and the introduction of elements of self-management. Again this area has not been a major focus of quality initiatives within the NHS, but has been partially addressed through organizational changes and devolvment of responsibilities to practice unit level, but in most instances this can be argued to have been marginal to the quality drive.
 - (9) Managers taking on the responsibilities of acting as role models. The major impediment to this might be seen to be the changing nature of the relationship between professionals and managers, and the conflict which has frequently been seen as a consequence of this change.
 - (10) Provision of feedback on management role. Unlike many commercial organisations, this has not generally been formalised in the NHS.
 - (11) The provision of recognition and rewards for quality improvements.

Whilst a few award schemes have emerged, these are far from universal in the current financial climate within the NHS, and it could be suggested that there has been more of a move towards negative sanctions rather than positive rewards.

- (12) The development and maintenance of appropriate processes for delivering quality. Although there have been attempts to utilise the information collected by way of clinical audit processes to develop quality protocols, this has been somewhat constrained by the focus on outcome measures as the primary measure of health care quality.

When considering the key components of quality previously identified - access, equity, acceptability, efficiency, effectiveness and appropriateness, a number of dilemmas have emerged as the attempts to quantify quality have developed. When appraising access to health care services, there is a need to incorporate not only issues relating to physical access, but also concerns about the range and level of appropriate services, as well as the distribution of such services. Such information is not consistently collated, as services undergo change and development, and access may vary within the financial year. In addition, responsibilities for access can be seen to be shared between purchasers and providers, and so the information available may be fragmented or incompatible. Therefore it is virtually impossible to comment on the quality of health care in terms of access in its broadest sense.

There are a number of components within the NHS, as it was initially established, that can be seen to relate to equity (Whitehead 1994):

- (1) Universal entitlement to health care.
- (2) Pooling of the financial risks associated with the procurement and provision of health care.
- (3) Health care services which are free at the point of delivery.
- (4) Universal high standard of care.
- (5) Selection of patients for treatment on the basis of clinical need, dissociated from the ability to pay for health care services.
- (6) The non-exploitative ethos which underpins the service.

(7) The 'feel good' factor.

Whilst challenges may frequently be made in the media that some of these components are being eroded, there is a lack of research evidence to confirm or deny such claims. However, the potential risk which is posed to equity in the use of block contracts, by way of both the opportunity and the incentive being given to provider units to 'cream skim', has been identified (Bartlett and LeGrand 1994).

When considering health care quality in relation to acceptability, again there arises the fundamental difficulty of the separation of the purchaser from the patient or consumer of the health care service, and whilst purchasers are charged with acting in the interests of the patients, there appears to be no consistent effort to determine what is considered as acceptable by the patient. Despite the greater emphasis on patient participation since the publication of Working for Patients (DoH 1989) and the identification in the Patient's Charter (DoH 1991) of the greater need for public involvement in health care decisions, progress has been patchy at best, and there remains little concern for the acceptability of health care provision in any individual sense.

Efficiency relates to the amount of benefit accrued from resources utilised, and some of the problems associated with measuring efficiency have been discussed earlier, and highlight the difficulties associated with quantifying what is essentially a human service. However the efficiency dimension of quality is one which will remain an important issue, as the demand for health care resources continues to exceed the supply. Although, as discussed, certain performance indicators have been devised, such as waiting times, which are used to measure the efficiency of the services provided, these remain very crude gauges which can be seen to fail to incorporate all of the factors which relate to efficiency. Four primary techniques for evaluating efficiency have been identified (Phillips, Palfrey and Thomas 1994):

- (1) Cost minimisation - which entails achieving the required outcomes at the least possible cost. It involves choosing between the range of strategies available for realizing stated goals.
- (2) Cost effectiveness - efficient service provision is judged to be that

which achieves greatest success for each unit of cost.

- (3) Cost benefit - utilisation of different strategies is likely to produce different outcomes, and so it is necessary to devise strategies for comparing costs and benefits achieved and choosing the strategy which accrues the greatest net benefit.
- (4) Cost utility - efficiency is evaluated by examining the utility of the intervention. Attempts to introduce the construct of Quality Adjusted Life Years (QALYs) as a measure of cost utility has remained largely in the domain of management theory, and there is little evidence to suggest that there has been any systematic attempt to determine the quality of service provision by utilising such methods.

There can also be seen to be an ethical consideration arising in relation to the efficiency component of quality, because when there are limited resources, as there always will be whilst health care demand continues to outstrip health care resources, then rationing decisions have to be made. If maximum efficiency is to be achieved, then those decisions could severely disadvantage the old, the disabled, the poor and those suffering from diseases which cannot be cured. Whilst care and palliative procedures can produce benefit for such groups, there is a risk that such benefit may be discounted if 'cure' is taken as the main or only criteria of effectiveness.

Decisions of this sort would not, of course, be readily acceptable to professionals, politicians or the public, and so whilst efficiency is sought, there appears to be an implicit understanding that it is sought only to a certain, unspecified, level. Although techniques can be identified for measuring efficiency, these are much more explicit in being able to measure the *cost* of services. The *benefits* of services do not have such easily identifiable measures and thus remain largely subjectively appraised, as objective measures remain underdeveloped.

One of the central aims of the NHS Reforms was to improve efficiency through the introduction of the internal market. The belief was that as hospitals competed for service contracts so efficiency would improve as hospitals devised strategies to ensure that they did not price themselves out of the market. However, this could only ever hope to be achieved if three conditions were fulfilled:

- (1) That a high cost hospital is so because of inefficiency and not because of any other factors, such as local conditions which result in unavoidably higher costs, or because the hospital is providing a quality of service which is better than its competitors. As yet, there is no reliable information which can be used to compare hospitals, other than financial information, and so judgements about whether a hospital is efficient may well be made on subjective rather than objective criteria. This cost/quality relationship is crucial since if costs directly reflect quality, purchasers must decide whether to opt for higher or lower quality.
- (2) It will be possible, and relatively easy to move patients from high cost, inefficient hospitals to low cost, efficient ones. It will always be simpler in theory than in practice to accommodate patients in anything other than their local hospital, and whilst some patients may be willing and prepared to travel for treatment, for some groups of patients, in particular the old and disabled, this may not be a viable option.
- (3) The cost data which is used to determine efficiency is both accurate and reliable. One of the major difficulties in the implementation of the NHS Reforms was that the quality of management information was poor, and evidence suggests that despite resource management programmes progress is slow and as yet the reliability of management information in the NHS cannot be assured (Packwood, Keen and Buxton 1991).

Similarly in relation to effectiveness, it can be seen that there is a need to develop measures which include more than a measure of changes in health status. In order for decisions to be made about the effectiveness of health service provision, the aims and objectives, in terms of measurable outcomes, must be explicitly stated, so that the actual achievements can be compared with those intended. Five major problems have been identified in relation to measuring the effectiveness component of quality in the NHS (Phillips, Palfrey and Thomas 1994):

- (1) Providers of health care services may often state their aims in rather vague terms, using concepts such as 'meeting need' without expressing

this in terms which can be measured.

- (2) Effectiveness cannot be correlated with the provision of a quality service. It is quite possible for an organisation to be effective, but to provide services which are inappropriate or under-utilised.
- (3) Effectiveness measures take no account of the cost of achievement, and so as a measure of quality cannot stand alone, but need to be considered alongside efficiency measures.
- (4) Improving effectiveness may have unintended consequences. An effort to improve effectiveness may lead to a reduction of in-patient stays, but result in a rise in re-admission rates. If this occurs the apparent improvement in effectiveness is spurious.
- (5) It is not always possible to link cause with effect. Apparent improvements in effectiveness could be related to factors other than the strategies employed to achieve this benefit, for instance improvement in social or environmental factors outside the influence of the health care provider, and possibly unknown.

Determining appropriateness of care is also problematic in that, again, it needs to include not only the professional perspective, but also the perspective of the patient, and indeed that of the society as a whole (NHSE Working Party 1993). From the professional perspective, despite the drive towards evidence based medicine, there is little consideration of the health care interventions of nurses, or the range of paramedical staff involved in the direct delivery of care to the patient. The wide variation in rates of procedures between areas, between hospitals and between individual medical practitioners lends support to the view that there must be wide variation in what health care professionals, and in particular doctors, believe to be appropriate care. Despite attempts to address this, change is slow. From a patient's perspective their judgement on the appropriateness of the health care they receive is determined not only by the level of their knowledge and understanding, but also by their values and belief systems, all of which will influence their view of the appropriateness of the health care they are offered. From society's perspective, the determination of the appropriateness of health care will depend on a number of

influences including economic, political, social and cultural factors, and as society undergoes change so will the social view on the appropriateness of a wide range of health care interventions. It is likely that this will not only influence the range of services which are provided, but also be an important criteria by which the quality of health care provision is judged.

Strategies for quality assurance in the NHS

When considering how the NHS has been seen to be attempting to assure the quality of care provided across the variety of provider units, there can be seen to have emerged five main strategies (Phillips, Palfrey and Thomas 1994):

- (1) Systems have been set up to carry out inspections, formal in connection to the statutory role of Health Authorities in relation to nursing and residential homes, and informal in connection to the advisory role of Community Health Councils in relation to Health Authority services. Three major limitations to inspection as a mechanism of quality control have been identified:
 - (a) Inspection visits are infrequent, and therefore cannot evaluate the process of the care which is carried out.
 - (b) In certain circumstances the inspector may be employed by the same authority responsible for the services being inspected.
 - (c) Formal inspections are usually structured around a given set of criteria, and offer little opportunity for the views of patients to be considered.
- (2) A procedure for conducting regular reviews of health services was established in 1982. Whilst such reviews provide a useful amount of service information, as a mode of quality assurance they are fairly restricted:
 - (a) Relating, as such reviews do, to the approved plans of the organisation, they are largely concerned with issues of efficiency and budgeting, and pay little attention to other issues, such as access, effectiveness, equity,

acceptability or appropriateness.

(b) Although the plans may have been devised with reference to professional staff and users, the review is the province of senior management, and thus does not seek the views of either the health care professionals or the patients.

(c) Reviews attempt to capture a broad picture of the organisation at the time at which the review is taking place, in relation to achieving the goals of the plans which have been made. There is little evidence to suggest that the review procedure, in itself, will have any impact on the quality of care provided.

(3) Systems of medical audit have been in place since the mid-1980s, evolving into systems of clinical audit following the NHS Reforms, however the effectiveness of such systems in promoting quality improvements has been challenged (Maynard 1991):

(a) The confidentiality with which such audits are carried out prevents the views of patients being taken into account.

(b) The standards which are used in clinical audit are devised, in the main, by professional staff, without reference to the patient.

(c) Even if clinical audit leads to quality improvements, there is no guarantee that these will be perceived as such by the patients.

(4) Performance indicators have been increasingly used to judge performance, since the new managerialism took hold in the 1980s, but whilst providing a wealth of statistical data, the usefulness of this can be questioned as a method of quality assurance:

(a) Again the determination of the standards used to construct performance indicators does not involve the patient.

- (b) The quantitative nature of performance indicators puts the focus on outputs rather than inputs.
 - (c) They take no account of the sophistication of local information systems, nor of differing priorities.
- (5) Patient satisfaction surveys have been widely used, over a long period of time, to evaluate the quality of services (McGhee 1961, Cartwright 1964, Raphael 1977, Gregory 1978), and although such mechanisms may be useful they, too, have their limitations:
 - (a) The assumption is made that patients have adequate knowledge of the available alternatives.
 - (b) The level of satisfaction will be dependent on the expectations of the individual, and so cannot claim to be an objective evaluation of health care services.
 - (c) The methodology of patient satisfaction surveys have proven to be limited, in the main, to questionnaires, the timing of which is likely to have a major effect on the results.

When considering the ways in which attempts have been made to set up systems of quality assurance in relation to the provision of health care services, it can be seen that a diversity of strategies has been utilised over time. None of these strategies can be seen to have provided a complete answer to the intricacy of quality service provision. The difficulties associated with quality assurance programmes had been recognised in the commercial sector, and related to the limitations of what was essentially a bottom-up approach to quality improvements and so such programmes expanded across organizations to include all of the activities happening within the organisation, and even to the external organisations which functioned as suppliers. Such an approach came to be known as Total Quality Management (TQM) and resulted in quality becoming a central focus of organisational aims (Joss and Kogan 1995). Integration of the TQM approach into the NHS has not been without its problems, and whilst some have argued against particular models of TQM in the NHS (Ovretveit 1990), others, including professional bodies have emphasised their

commitment to it (RCN 1991). The NHS appears to have experienced particular problems in the incorporation of existing quality assurance programmes into a new TQM programme (Dalley and Carr-Hill 1991). A detailed study of the implementation of TQM at 38 NHS units concluded that it was not successfully implemented at more than two sites (Centre for the Evaluation of Public Policy and Practice 1994). This suggests that in the transposition of TQM from the commercial sector to the health care sector, its power to transform the culture and practice of an organisation is lost.

Factors which are significant in the provision of health care can be seen to relate to two (structure and process) of the three elements of quality - structure, process and outcome (Donabedian 1969) which can in turn be seen to relate to the key components previously identified. Having already determined the problems which exist in relation to the outcomes of health care, there also needs to be a consideration of how structure and process factors might influence the quality of health care.

Structural factors influencing the quality of health care

When considering the structure of health care services, this can be seen to have undergone major changes throughout the history of the NHS, and even more so since the implementation of the NHS Reforms, and yet evidence of the effect of structural changes on the quality of care is sparse. In the commercial world successful organisations are seen to be those which are characterised by a culture which is both dominant and homogenous (Peters and Waterman 1982). These are not characteristic features of the post-Reforms NHS. Indeed there is some evidence to suggest that the implementation of the NHS Reforms, through changing the underlying values of the NHS, has resulted in a more divisive culture which highlights areas of conflict within the organization (Caldwell and Francome 1993, BMA 1994, Francome and Marks 1996). It was generally accepted that there was a need to transform the culture of the NHS, if the Reforms were to succeed, and to encompass professional staff within the new managerialism. Whilst the importance which was accorded to this can be seen to be reflected in the amount of both energy and resources utilised to 'sell' the Reforms to the professional bodies, success was limited as can be seen by the largely

negative response of the professionals to the changes. However, there is some evidence to suggest that at least some professionals viewed the Reforms as a means by which they could enhance their professional power base. It has long been recognised that whilst doctors working within the NHS had a high degree of technical and political autonomy, they had lacked any economic autonomy (Friedson 1977). It could be argued that although the NHS Reforms might be seen to have reduced the political autonomy of doctors, without any real change in their economic autonomy, their position could in fact be strengthened by their greater involvement in general management (Elston 1991). However, there has been no systematic review of the way in which this increased involvement of doctors in management of health care services has impacted on the quality of patient care, if there has been such an impact. One study which has specifically examined quality of care in relation to health service structure revealed that 62% of respondents, including both management and clinical staff, believed that there had been a detrimental effect on the quality of work which was related to its sheer volume (Appleby et al 1994).

In many ways the structural elements of quality can be more easily measured than the elements of process and outcome, and so data is more easily available. Several structural aspects of care which relate to quality have been identified, one common measure used is to relate numbers of specialists available in relation to population (Hopkins 1990). The major difficulty associated with this is that there is no universal agreement as to the numbers of specialists required, and whilst attempts have been made to arrive at agreed figures, such agreements are by no means fixed. However, what can be achieved by such measures, is that distribution of resources across the country can be compared, and inequalities in distribution which will result in inequalities of access can be recognised. Another structural influence on the quality of health care can be seen to be the quality structure itself, including the existence of organizational standards against which achievements can be measured, and the process of clinical audit.

Process factors influencing the quality of health care

When considering the process element of health care quality, the focus turns from the

macro elements of the organisation to the micro elements of the interaction between the patient and the direct provider of the health care intervention. The importance of this interaction is well acknowledged as being the foundation on which quality of care is derived and judged (Einstat and Felner 1983), and so it is evident that the interpersonal as well as the technical component of care is one which determines the patients' perceptions of the quality of health care they receive. Thus the way in which health care professionals practice has a significant impact on the quality of care, and factors which can be seen to disrupt this practice, or impede the interpersonal interaction between professional and patient, will have a detrimental effect on that quality of care.

It has often been suggested that the effects of stress on those providing care has proven to be such a disruption. The issue of stress in relation to health care professionals has been well researched both in terms of cause and effects. When considering the causes of stress, lack of support (Hingley and Harris 1986), excessive workload (Cassem and Hackett 1972, Gray-Toft and Anderson 1983, Sutherland and Cooper 1990, Wheeler and Riding 1994), organisational and management issues (Harvey 1992, Wheeler and Riding 1994), poor relationships (Cassem and Hackett 1972, Gray-Toft and Anderson 1973, Wheeler and Riding 1994) and poor working conditions or facilities (Wheeler and Riding 1994) have all been identified. The effects of stress on health care professionals in relation to the quality of care they deliver has also been explored, and one such effect is seen to be a shift in the way they view patients, from positive and caring to negative and uncaring (Spencer 1986), another is the avoidance of decisions, problems and changes (Firth et al 1986), areas which clearly illustrate the relationship of professional stress to quality of care.

A further process factor which has been seen to be significant in relation to the quality of health care provision is the pattern of work organization, and a system of work which promotes individualized, personalized care is one which is likely to enhance the quality of care (Wells 1980, Redfern and Norman 1990). Obviously the provision of an individualized system of care is likely to have serious cost implications, and thus as the drive for efficiency gains momentum, the possibility

exists that conflict will emerge between two of the components of quality - structure and process.

Quality of care and the NHS Reforms

Improving the quality of care provided by the NHS was a key aim of the NHS Reforms, one which has been subject to much debate and speculation but little in the way of in-depth evaluation. When examining the key components of quality there can be seen to be some movement resulting from the implementation of the Reforms. When considering access to health care services, the change which has resulted in most impact is the creation of GP fundholders which can be seen to have provided a fast track to both hospital consultations and admission for elective surgery, thus allowing the patients of GP fundholders to enjoy improved access to services not so easily accessible to the patients of GPs who are not fundholders (Mahon and Wilkin 1994, Francome and Marks 1996). Another issue which can be seen to relate to access, is that the government chose to localise decision making in relation to rationing and priority setting (Bouffard 1992), and whilst this was argued to allow greater responsiveness to local needs, it also means that geographical differentiations in access are likely to worsen over time. Whilst one area of access, that of waiting times, has been extensively studied, and be seen to have improved since the implementation of the NHS Reforms, other areas which have been identified such as accessibility *within* hospitals have been largely ignored. The issue of covert inaccessibility through ignorance, apathy or rationing by GPs, is neither well recognised nor articulated in the NHS (Hopkins 1990), and this is something which the NHS Reforms did not make any real attempt to address. More overt forms of rationing have also appeared as purchasers made decisions not to fund certain procedures such as in-vitro fertilisation and tattoo removal (Dean 1991, Woodman 1993).

When considering the impact that the NHS Reforms have had on the quality component of equity, there is a significant lack of data, as well as a lack of consensus as to how equity should be determined:

It is not that easy to ascertain the precise notion of equity adopted by the

NHS. This ambiguity creates some problems, because each notion carries a different ideological weight and has different policy implications. It seems to be the case that equality of access (and not utilisation) has been and remains, post reform, the principal equity objective behind the NHS. As such, in theory, there is no a priori reason to believe that the post reform NHS is less equitable. (Malek, Vacani and Rasquinha 1993 p 249)

Indeed, it has appeared to be the case that the rather narrow definition of equity which relates to access only, has resulted in only partial data being available on which to evaluate the effects of the NHS Reforms on equity. There has, for instance, been little exploration of the ways in which different client groups have experienced the effects of changes in the NHS, and whilst differences have appeared in relation to patients of fundholding GPs as compared with non-fundholding GPs, there has not been a systematic review of the groups of patients which have been most affected. There is also a divergence of opinion as to the overall effects of the Reforms on equity, and whilst some have claimed that the Reforms have been associated with greater inequality (Hudson 1992, Pearson 1992, Whitehead 1994), others have argued that there has always been inequality in the NHS, and the Reforms have merely made that inequality more visible (Powell 1996).

With regard to the acceptability of care, several commentators have highlighted the idea that health service provision needs to be acceptable not only to the patient, but also to the staff who are the direct providers of care, and who may also become patients at various times during their lives (Hopkins 1990, Bell, Brown and McCartney 1993). However, obviously this acceptability has also to relate to the willingness of the purchasers to finance the service, yet there has been no concerted attempt to delineate the concept of acceptability, let alone to attempt to align the different concepts of acceptability which may exist in relation to purchaser, provider and patient. Despite the fact that greater patient participation is encouraged in the post-reform NHS, there has been no systematic attempt to determine whether or not services are, in fact, more acceptable to patients now than before the Reforms were implemented. Although it might be supposed that the acceptability of health care provision could in some way be determined by patients' expression of satisfaction or

dissatisfaction, this can be a notoriously misleading measure in terms of reliability and validity (Bond and Thomas 1992). Another method which has been widely utilised as a way of determining the acceptability of care from the patient's perspective has been in the recording of levels of complaints, and whilst there is much evidence to suggest that these have risen since the NHS Reforms were implemented, this cannot be taken to expose a worsening in quality, in fact the reverse may be the case if provider units are making it easier for patients to complain, and are improving recording of complaints received.

As previously stated, claims that the NHS has functioned more efficiently since the implementation of the Reforms has largely focused on improvements in certain performance indicators such as waiting times and throughput rates, and at first sight it would certainly appear that better value for money is being achieved, as the amount of health care provided seems to be rising more rapidly than the amount of resources being utilised. However, as a measure of quality these performance indicators are lacking in substance as they fail to consider all three elements of quality (structure, process and outcome) and the possibility exists that if one element improves another may deteriorate. Unless all three elements are monitored this may not be detected.

Measuring the effectiveness of health service providers in terms of outcomes has been, arguably, the least developed measure of quality, a deficiency which has been identified, but as yet not rectified. Whilst in the past the effectiveness of care has largely been evaluated by measuring the adverse outcomes of care such as peri-operative mortality rate, or hospital acquired infections, and such information remains valuable, there is also a need to evaluate the positive effects of care. To determine the quality of outcomes of health care intervention requires the explicit definition of aims of care in terms not only of health status, but also in terms of well-being, and as yet such work has not been developed adequately enough for meaningful comment to be made about the impact of the NHS Reforms on effectiveness of health care.

The final component of health care quality, that of appropriateness has perhaps been best defined by the RAND corporation:

Appropriate (care means) that the expected health benefit (ie increased life expectancy, relief of pain, reduction in anxiety, improved functional capacity) exceeds the expected negative consequences (ie mortality, morbidity, anxiety of anticipating the procedure, pain produced by the procedure, misleading or false diagnoses, time lost from work) by a sufficiently wide margin that the procedure is worth doing (RAND 1986 cited in Hopkins 1990 p 6).

Appropriateness of care incorporates not only utilisation, but also under-utilisation of health care services. The drive towards evidence based medical care has attempted to address the issue of appropriateness of care, through the development of recommended protocols for particular clinical conditions, the issuing of clinical guidelines, and the monitoring of adherence to such guidelines (Grimshaw and Russell 1993, Appleby, Walshe & Ham 1995), and such strategies are becoming more commonplace in both hospital and GP practice. As yet the data which would enable the effects of the Reforms on appropriateness of care to be judged is not available, and it may well prove impossible to separate the effects of the Reforms from other developments (e.g. in medical research) which are unrelated to them.

The further the effects of the Reforms on the quality of health care are explored the more unclear and uncertain the picture becomes. Information is partial and often crude, and in many cases can be seen to be structured by ideology rather than by objectivity. Without doubt there have been improvements in quality in some areas and deteriorations in others, but what is lacking is a systematic review of quality across the NHS. Even if this is carried out, it is by no means certain that the full impact of the Reforms on the quality of care would be revealed. Quality is in itself a complex and dynamic concept, and the NHS a complex and dynamic organisation, and it may well be unrealistic to hope to achieve more than a idea of general trends in quality, even though the notion of measurability remains important and will continue to develop.

CHAPTER 7

THE NATURE AND SCOPE OF THE IMPACT OF THE NHS REFORMS ON PROFESSIONAL PRACTICE

Implementation of the NHS Reforms

In the interviews with senior managers of Greenfield, Stockton and the Health Authority, and doctors and nurses working within both hospitals, similarities and differences in the approaches of the two hospitals to full implementation of the NHS reforms were revealed. Perhaps the most significant of the differences was in the pace of change, Stockton applying for Trust status in the first wave, and Greenfield adopting a more staged approach. The result of this was that Stockton became an NHS Trust some two years before Greenfield.

There had been no scope for people to think creatively, and to come up with their own ideas, and again that was something we wanted to address by taking over the direct management of the hospital as soon as we could. (Senior manager, Stockton)

We had to determine what and how much we were doing...so that was the first stage. The second was to work out what our costs really were, and then try to apportion and attribute them sensibly and realistically. (Senior manager, Greenfield)

Despite their different approaches to the timing of full implementation, in general there was consensus within the management of both hospitals and in the Health Authority that the NHS reforms represented positive health policy.

I am actually very pro-reforms and I think that it is possibly the best thing that has ever happened to the health service. (Senior manager, Greenfield)

The reforms have allowed us to get on with the business we do best - providing health care - without the previous requirement to go through endless tiers of bureaucracy, it got rid of the external hierarchy. (Senior manager, Stockton)

The reforms encouraged the hospitals to really think about what they are doing, and what they are able to do, and what they need to do, they allowed things to happen more quickly, and provided the motivation - through competition - for hospitals to do all they could to improve their service provision. (Senior manager, HA)

Whilst the professionals working within the hospitals were more likely to voice concerns about the nature of the reforms, there was a widespread recognition that some form of change was necessary.

Of course it had become increasingly obvious over recent years, that the NHS could not continue to absorb the ever-increasing costs, there needed to be some changes so that we could use resources more efficiently - but that doesn't mean that I approved of all the things that happened. (Nurse, Greenfield)

I recognised that the NHS needed to be overhauled, but what they have done is throw the baby out with the bathwater. Surely we should have tried to save what was good, and improve what was not, instead we destroyed everything, good and bad. (Doctor, Stockton)

We all realised that we couldn't go on with the ideas of a previous generation, there needed to be change, but I think that the change needed to build on our strengths instead of trying to bring big business into what is still, after all, a public service. (Doctor, Greenfield)

Things weren't perfect, I accept that, but did we really need to start treating patients as if they were tins of beans on a supermarket shelf? (Nurse, Stockton)

The management of both hospitals believed that if the reforms were to be successful, then they had to be both understood and supported by the professional staff working within the new system, and the key step in both Greenfield and Stockton was seen to be communicating the changes effectively.

We needed to get our professional staff on board....we knew that they would be very influential in this. We spent a lot of time doing what we called roadshows, an over-the-top title perhaps, but we were going round at all hours of the day and night discussing our plans with the staff, outlining what we saw as the benefits of becoming a self-governing Trust, and hearing what their views on it really were. (Senior manager, Stockton)

So making sure that staff at all levels of the organisation from ward staff to consultants to finance and managerial staff understood what the basic principles of contracting were, and the information that was required in order to operate the system, was absolutely key to success. (Senior manager, Greenfield)

So through the staff side, and through open meetings, I ran, I think, about half a dozen open sessions on contracting, we got the information through. In total about 300 staff, from a total of 1500 employed, attended these meetings. (Senior manager, Greenfield)

A different approach to the communication process between the two hospitals can be discerned. Stockton adopted a technique which attempted to *sell* its proposed changes to the staff who would actually determine their success, whereas the management of Greenfield focused on ensuring at least a basic level of understanding of the implications of the externally imposed changes as the first step. There was evidence from staff at all levels and in both hospitals that calls into question the effectiveness of communication about the Reforms.

I can still walk round the wards and find a number of staff who don't

understand the relevance of the way in which the health service works now.
(Senior manager, Greenfield)

I really think that, whilst the managers may have got to grips with the changes, many of the grass roots staff remained in the dark. (Senior manager, HA)

I became very aware that there were a lot of people about who had no clear idea about what was going on - no understanding of what the purchaser/provider split was going to mean, and I myself was very unclear about what some of the changes were, and it was only after a few years that I began to appreciate the implications of GP fundholding. (Nurse, Greenfield)

There was no idea of negotiation or even discussion, we were told what we had to do. Now you would think, wouldn't you, that someone would have sat down and asked me how I thought the changes should be introduced in my own department, after all, surely I am the one that would have the most understanding? (Doctor, Stockton)

There seemed to be differences of opinion as to how these changes would affect the way we worked, everyone seemed to be saying something different.
(Doctor, Greenfield)

For a long while I thought that these changes were nothing to do with me really, and I found it hard to see why they would change the way we worked. I found out the hard way! (Nurse, Stockton)

Whilst a number of doctors and nurses identified their feelings of being threatened by the changes, this was obviously given closer consideration by the managers of Greenfield than of Stockton. Whether or not this attention allayed any of the fears remains open to question.

Clearly our professional staff had a lot of concerns, most of them needless, as it happens. We would have control of our own destiny as a result of the Reforms, and that must be better for everybody. (Senior manager, Stockton)

Although we were reassured that there would be no redundancies I for one found it hard to believe that, when everything I saw on television or read in the newspaper seemed to contradict that. (Nurse, Stockton)

All staff, and I mean all staff, needed to understand that there was no guarantee of a pay cheque unless we could secure contracts which paid us to treat patients that the purchasers wished us to treat as opposed to the patients that we wanted to treat. (Senior manager, Greenfield)

Senior staff were saying to as many people as possible that it did not mean by becoming a Trust, this would mean redundancies. It was also extremely important to make clear the realities of the world. Trust status and redundancies were not linked, but that if we lost contracts, redundancies would follow. (Senior manager, Greenfield)

I felt that the possibility of redundancies was used as a threat, not to the medical staff perhaps, but certainly to nurses and others. (Doctor, Greenfield)

The initial impact of the Reforms

One area in which change was immediately apparent was in the way in which relationships were remodelled, and it became evident that there were some difficulties both related to the development of new roles and relationships, and the deconstruction of those roles and relationships which had characterised the pre-Reforms NHS.

Some GP fundholders were attempting to use their new freedom to settle old scores. (Senior manager, Greenfield)

It was a big change in terms of our relationship with them (the HA) but in

terms of their relationship with us it didn't seem so very different, because they had always seen themselves as the allocators of money. In the past, of course, they had a very big stick with which they could beat us - a block allocation of so many million pounds, and there was no limit as to what they could demand that we did with it. The contracting process did give us a bit more control, and that is why it felt different to us, we could actually say - well you have only given us money to do so many cases, and now that we've done those we won't do any more unless you give us more money. (Senior manager, Stockton)

The vast majority of people that I sat across the table from in terms of contract negotiations had never done that sort of job before, and therefore had never had to develop those skills...they don't all understand the nature of negotiation, it is just not the case that we are given a contract and that is the end of it, the terms must be negotiated. (Senior manager, Greenfield)

It became obvious to me that they (the purchasers) had huge amounts of detail about Stockton hospital, and a very close relationship with them, and my view is that this is inappropriate when you get round the negotiating table, in terms of where contracts are placed. (Senior manager, Greenfield)

I tend to get myself very involved in terms of service development issues because I'm very interested in that area, and we work very differently with the different Trusts, because they have different ways of carrying out their business. (Senior manager, HA)

It took a while for relationships to break down and reform in a rather more constructive fashion, and I think that took us about two years to achieve. (Senior manager, Greenfield)

The major difference between the two hospitals in terms of purchaser/provider relationships could be seen to be in the importance of GP fundholding.

GP fundholding is very underdeveloped in this area, there's only five fundholders, which represents a very small part of our budget. (Senior manager, Stockton)

We were unusual in a sense that, as a proportion of our income being in the hands of GP fundholders, we had the biggest proportion in the country of money being in the hands of GPs - 4% - so although it does not sound much in relation to the totality, if we lost 4% of our elective work, trying to make those savings would actually be very painful. (Senior manager, Greenfield)

I think that GP fundholding has been a very positive change, the day of the arrogant consultant who didn't care about the GP has gone, although the transition has not always been an easy one. (Senior manager, Greenfield)

There is no clear consensus as to whether or not the implementation of GP fundholding has led to the development of a two-tier service, although it is obvious that this is a matter over which there was, and still is, considerable concern, certainly at Greenfield, where such fundholders have greater importance in relation to the overall budget.

We're not at all sure that we're keen on what is inevitably a two-tier service if you have a greater number of GP fundholders. (Senior manager, Stockton)

I think that we have had relatively few problems, compared with some hospitals, because we have far fewer fundholding GPs who might like to start dictating what we should be doing, when really they have very little idea how a modern hospital functions. (Doctor, Stockton)

It is just not the case that the patients of fundholding GPs get a better service. Yes, we might have to improve our service to get the contracts from the GPs, but then that service is improved for all patients, not just the patients of the fundholders. (Senior manager, Greenfield)

Well, unfortunately, and as distasteful as we might find it, I have to say that yes, the patients of GP fundholders do get a better deal, especially when we have completed the contracts for the Health Authority, and you only have to consider the benefits of outreach clinics, for example. (Doctor, Greenfield)

There is a genuine concern that patients coming from GP fundholders will get priority, in reality I don't believe that this happens a great deal, but the potential is there, and really there is no difference between the patient who has their treatment funded by the Health Authority or the patient who has their treatment funded by their GP - or at least there shouldn't be. (Nurse, Greenfield)

An almost immediate impact from the Reforms was in the emergence of a whole range of new activities which were to take up a great deal of time, certainly for some individuals.

As far as I am concerned I would think that about a quarter of my life is spent in contract discussions and negotiations, which is not really what it is all about. (Senior manager, Greenfield)

There is an absolutely incredible bureaucracy accompanying the internal market, much of my time is spent in a morass of paperwork, often having to replicate what appears to me to be meaningless trivia. (Senior manager, Stockton)

I spend a lot of time involved with service reviews which take the form of an in-depth visit. Although the visit may only be one day, or even a half day, the preparatory work is very detailed. A questionnaire for a service review frequently runs to fifteen pages or more, including more than fifty questions....these are given out three to four weeks in advance of the visit so that everyone in the team can be involved....When we make the visit we will go through the questionnaire in some detail, discussing and elaborating on the

answers. (Senior manager, HA)

Consultants have had to become much more rigorously involved in the business side of the work we do, over half of our consultants are actively involved in management. (Senior manager, Greenfield)

I now have a far greater management load, very little of my time used to be spent on what I would consider purely management activities, now most of my time is. (Nurse, Greenfield)

I've had to learn how to manage a budget, and control patient throughput in relation to our contracts, I feel I'm a manager now, not a nurse. (Nurse, Stockton)

To my surprise I was expected to become involved in marketing, now I ask you, would you ever have expected to see the day when a senior hospital consultant would be required to tout for business? But I must say that I think our meetings with local GPs have been very productive, so I am not so anti the business approach now as I was in the beginning. (Doctor, Greenfield)

Reflections on the success of the NHS Reforms

Following implementation of the Reforms a significant number of the individuals involved found that ideas underwent a change as they lived through the reformation.

Please don't get the idea that I am in favour of returning to the old hierarchy, but we must develop networking between professional groups, on a national basis. It concerns me that so many professionals, and I see it more of a problem for nurses than for doctors, are working in isolation within their Trusts. There are signs that this is being addressed, but not with any consistency. (Senior manager, HA)

I am disillusioned, but that is merely because of the bureaucracy....Region are

still there, they may not be as powerful as they once were, but still able to stick their oar in, to put it bluntly, as are the NHS Executive ...there's no doubt it does constrain. (Senior manager, Stockton)

At the moment it really is a dog-eat-dog type of relationship between providers, they refuse to give us information about what they are doing, people are very secretive, and will do all they can to take business away from us. It's all very predatory and really not very nice. I feel very strongly that at the end of the day this is not a business, it's a public service. (Senior manager, Stockton)

It's not working as it should, there's little sign that any real needs assessment is being carried out so purchasing tends to be related to historical patterns. There is no sign of long term strategic planning at all, and a big problem is that trying to negotiate on a yearly basis does actually disrupt the organisation, and gives us no stability at all. If you took the contracting process to its logical conclusion then I take a gamble on every member of staff that I have whilst we have one year contracts at a maximum. (Senior manager, Greenfield)

The so-called brave new world of the new NHS has proved to be somewhat of a damp squib. We haven't got rid of the old problems, although we seem to have added plenty of new ones, I only hope that when the next big change comes - and come it will - we will all have learnt from the mistakes of the past few years. (Doctor, Greenfield)

I think that the NHS reforms have created far more problems than they attempted to solve, I feel I've been to hell and back, there's been so much pressure. (Nurse, Stockton)

The characteristics of the sample studied

To determine the extent of the impact of the NHS Reform on the practice of clinically

based doctors and nurses a total of 194 questionnaires were distributed as described previously. Consideration was given to the probability that there would be differences which would emerge in relation to the area of clinical speciality, and so this was one of the key variables identified within the sample. The possibility was considered that the Reforms had different effects according to clinical speciality. The main areas identified were medical, surgical, trauma/orthopaedic, intensive care, theatre/anaesthetics and paediatrics. The category Medical includes both general medical services, and specialist services such as neurology and cardiology (both in-patient and day care). Surgical includes general surgery and various surgical specialities such as urology, gynaecology and ear, nose and throat, again both on an in-patient and day care basis. Whilst the same specialities are not identical between the two hospitals, they share similar characteristics in relation to case-mix and throughput. Trauma/Orthopaedics includes Accident and Emergency services, admission units, elective orthopaedics and trauma services. Intensive Care includes only those professionals working solely in a dedicated Intensive Care facility and likewise Theatre/Anaesthetics includes only those professionals working solely within the area, rather than using theatre facilities eg, surgeons are not included in this category, as they are theatre users rather than designated theatre staff. The category of paediatrics includes those professionals working in areas designated solely to caring for children. The category other includes those relatively few clinically based professionals working in related departments such as pathology, radiology and out-patient services.

Of these 194 questionnaires 11 were returned as unavailable for the survey due to death, retirement or long term sick leave, leaving an effective sample of 183. Following a second mailing and reminders 129 questionnaires were returned, a response rate of 70.49%. The characteristics of the respondents can be identified in tables 7.0 to 7.3. There do not appear to be any differences between the characteristics of the responders and the non-responders. One respondent failed to give details other than profession and hospital.

Table 7.0 Respondents by hospital and profession

	Doctors	% of respondents	Nurses	% of respondents
Greenfield	28	21.7%	45	34.9%
Stockton	21	16.3%	35	27.1%
Total	49	38.0%	80	62.0%

Table 7.1 Respondents by length of service in NHS

Length of service	Number	% of respondents
Under 5 years	4	3.1%
5-9 years	12	9.4%
10-14 years	32	25.0%
Over 15 years	80	62.5%

Table 7.2 Respondents by length of service in present post

Present post	Number	% of respondents
Under 5 years	43	33.6%
5-9 years	43	33.6%
10-14 years	12	9.4%
Over 15 years	30	23.4%

Table 7.3 Respondents by area of clinical speciality

Area of work	Number	% of respondents
Medical	34	26.6%
Surgical	36	28.1%
Trauma/Orthopaedic	15	11.7%
Intensive care	9	7.0%
Theatre/Anaesthetic	13	10.2%
Paediatric	15	11.7%
Other	6	4.7%
Total	128	100%

Changes to workload

As suggested by the Delphi study workload was viewed by the respondents as being an area of their practice which had been particularly affected by the implementation of the Reforms.

I've never had to work so hard as I do now, nursing has always been hard physical and emotional work, but I'm now having to work longer and longer hours to keep up with the work I have to do. (Nurse, Stockton)

The working day has extended remarkably, I now often have to attend meetings either before or after a full day of seeing patients. (Doctor, Greenfield)

The only way that we can keep up with the workload we are expected to carry is to work more and more unpaid overtime, a certain amount of this has always been part and parcel of a ward sister's job, but I get the impression that it's now required, not just a matter of good will. (Nurse, Greenfield)

I've had to take on more and more management duties, yet no-one has taken

on any of my clinical load. (Doctor, Stockton)

This increase in workload is consistent across both hospitals (Table 7.4) and both professions (Table 7.5).

Table 7.4 Extent of change in level of workload by hospital

Workload	Greenfield	Stockton	All
Greatly increased	38 (52.0%)	28 (50.0%)	66 (51.2%)
Increased	33 (45.2%)	26 (46.4%)	59 (45.7%)
Unchanged	2 (2.7%)	1 (1.8%)	3 (2.3%)
Decreased	0	0	0
Greatly decreased	0	1 (1.8%)	1 (0.8%)

Table 7.5 Extent of change in level of workload by profession

Workload	Doctors	Nurses
Greatly increased	25 (51.0%)	41 (51.3%)
Increased	20 (40.8%)	39 (48.7%)
Unchanged	3 (6.1%)	0
Decreased	0	0
Greatly decreased	1 (2.0%)	0

The increase in workload appears across all areas of work, differences emerging only in the rating of professionals as to whether the workload has been increased or

greatly increased (Appendix 1)

What became evident during the interviews was that professionals were very concerned about the changing balance of their workload, as well as the level of workload itself.

I seem to work more as a manager than as a nurse nowadays, there is more and more administrative work which has to be done. (Nurse, Stockton)

There is an ever-increasing amount of paperwork to be done, whereas a phone call may have sufficed in the past now I have to complete a two page form in triplicate. However despite this, no-one has seen fit to reduce my patient load, not that I would have wanted them to - but what it means is that I cannot be so available to support my junior staff. (Doctor, Greenfield)

More and more paperwork means less and less time for patients. (Doctor, Stockton)

...a never-ending mountain of paper, most of it not directly related to patient care. (Nurse, Greenfield)

This concern, even consternation, about the disproportionate increase of indirect care and administrative workload, can be seen to be in direct conflict with the policy aims of recent years. The nurses' clinical grading during the 1980s and the increase in consultant posts during the 1990s were both aimed at creating a clinical environment in which care was delivered by those with the greatest knowledge, skills and experience. However, the implementation of the NHS Reforms led to a shift away from direct care in the balance of workload of senior doctors and nurses and can be seen to have unintentionally created increased bureaucracy.

Although there was an increase in all areas of workload this increase was greatest in relation to administration, and least when considering direct care. The increased

workload in relation to direct care can be seen across both hospitals (Table 7.6) and professions (Table 7.7).

Table 7.6 Extent of change to level of direct care carried out by hospital

Direct Care	Greenfield	Stockton
Greatly increased	11 (15.1%)	7 (12.5%)
Increased	24 (32.9%)	25 (44.6%)
Unchanged	25 (34.2%)	11 (19.6%)
Decreased	11 (15.1%)	11 (19.6%)
Greatly decreased	2 (2.7%)	2 (3.6%)

Table 7.7 Extent of change to level of direct care carried out by profession

Direct Care	Doctors	Nurses
Greatly increased	9 (18.4%)	9 (11.3%)
Increased	17 (34.7%)	32 (40.0%)
Unchanged	17 (34.7%)	19 (23.8%)
Decreased	4 (8.2%)	18 (22.5%)
Greatly decreased	2 (4.1%)	2 (2.5%)

This increased workload in relation to direct care can be identified throughout the various clinical areas (Appendix 2).

When considering indirect care, that is care that is patient focused, but is not carried out in direct contact with the patient, an increased workload can be confirmed. This is a change which extends across both hospitals (Table 7.8), and professions (Table 7.9) in a similar pattern.

Table 7.8 Extent of change in level of indirect care carried out by hospital

Indirect Care	Greenfield	Stockton
Greatly increased	24 (32.9%)	21 (37.5%)
Increased	34 (46.6%)	24 (42.9%)
Unchanged	15 (20.5%)	10 (17.9%)
Decreased	0	1 (1.8%)
Greatly decreased	0	0

Table 7.9 Extent of change in level of indirect care carried out by profession

Indirect care	Doctors	Nurses
Greatly increased	13 (26.5%)	32 (40.0%)
Increased	23 (46.9%)	35 (43.8%)
Unchanged	12 (24.5%)	13 (16.3%)
Decreased	1 (2.0%)	0
Greatly decreased	0	0

The changes in relation to indirect care can be seen to extend across all areas of clinical speciality (Appendix 3).

When considering administration, that is work which is neither patient focused, nor carried out in direct contact with the patient, again there can be seen to be an increased workload which spans both hospitals (Table 7.10). There also appears to be little difference between doctors and nurses in relation to the increased administrative workload, with more than nine out of ten in both groups claiming that this has been greatly increased or increased (Table 7.11)

Table 7.10 Extent of change in level of administration carried out by hospital

Administration	Greenfield	Stockton
Greatly increased	37 (50.7%)	34 (60.7%)
Increased	31 (42.5%)	19 (33.9%)
Unchanged	5 (6.8%)	3 (5.4%)
Decreased	0	0
Greatly decreased	0	0

Table 7.11 Extent of change in level of administration carried out by profession

Administration	Doctors	Nurses
Greatly increased	31 (63.3%)	40 (50.0%)
Increased	14 (28.6%)	36 (45.0%)
Unchanged	4 (8.2%)	4 (5.0%)
Decreased	0	0
Greatly decreased	0	0

There is a similar pattern emerging across all clinical specialities, which confirms that the increased workload is a shared experience across hospitals, professions and clinical specialities (Appendix 4). It is not evenly distributed across all categories of work, and in all areas although there has been a uniform increase, this increase is greater in relation to indirect and administrative care. It appears that there has been a shift away from direct care towards indirect care and administration.

Conflict with managers

A further area explored during the survey was that of conflict with managers, an area

which emerged as significant during the Delphi study, and which was confirmed both during the interviews and through the survey

I don't feel the managers have any idea of what care is all about - it's a real them and us situation. (Nurse, Stockton)

I feel that I am always having to battle with the managers to achieve anything at all. (Doctor, Greenfield)

Every day it's a fight with the management to get what we need to do our job. (Doctor, Stockton)

I think that conflict with our managers is inevitable, it's as if we are trying to aim for different things. (Nurse, Greenfield)

Some respondents chose not to answer this question but, nevertheless, an increase in the level of conflict between doctors and nurses and their managers could be seen across both hospital sites (Table 7.12).

Table 7.12 Extent of change in level of conflict with managers by hospital

Conflict	Greenfield	Stockton	All
Greatly increased	27 (37.0%)	21 (39.6%)	48 (38.1%)
Increased	34 (46.6%)	21 (39.6%)	55 (43.7%)
Unchanged	11 (15.1%)	8 (15.1%)	19 (15.1%)
Decreased	1 (1.4%)	1 (1.9%)	2 (1.6%)
Greatly decreased	0	2 (3.8%)	2 (1.6%)

The pattern of increasing levels of conflict with managers was similar both between doctors and nurses (Table 7.13) and across all clinical specialities (Appendix 5)

Table 7.13 Extent of change in level of conflict with managers by profession

Conflict	Doctors	Nurses
Greatly increased	19 (38.8%)	29 (37.7%)
Increased	18 (36.7%)	37 (48.1%)
Unchanged	9 (18.4%)	10 (13.0%)
Decreased	1 (2.0%)	1 (1.3%)
Greatly decreased	2 (4.1%)	0

Changes to levels of stress experienced

The final area which was the subject of direct inquiry was that of changes in the level of stress generated by professional practice, as a direct result of the NHS Reforms. This had been a recurrent theme in the professional literature, and predictably emerged during the Delphi study as being an important effect of the implementation of the Reforms. Indeed this was upheld by the survey which revealed that 118 (91.4%) respondents were experiencing increased or greatly increased levels of stress in their practice. Whilst these levels of increased stress may well be a secondary rather than primary effect of the NHS Reforms, related possibly to increased workloads and increased levels of conflict with managers, there can be no doubt that this must be of considerable concern to both the professionals concerned and also to the managers, as the effects of stress take their toll. During the interviews the unacceptability of the increasingly stressful experience of professional practice was a repeated theme.

The pressure is immense, I feel like I'm on a treadmill, and I just can't get off. I eat, breathe, sleep and dream about work - it never leaves me, sometimes it all gets so much that when I eventually go home I feel guilty about not being at work. My family just can't understand the pressure I'm under. (Nurse, Greenfield)

I can't take any more, I'll be retiring in a few weeks, I never wanted to retire

early, but I'm afraid that if I don't go soon it will kill me. (Doctor, Greenfield)

I know it makes me sound a bit of a wimp but some mornings I just can't bear to get out of bed, I don't know how I'll be able to stand the stress of trying to please the patients, the doctors, the managers and everybody else. They keep telling us we have got to manage better, but we're having to do more and more with less and less, and it won't change unless there's either a real disaster or a miracle. (Nurse, Stockton)

Life in the health service has always carried a certain level of stress, we expect that, and our training equipped us to handle it, but nothing like we're seeing now. I think, no - I know that there is an awful lot of distress around, people who have always been strong are crumbling under the pressure. (Doctor, Stockton)

Increased experience of stress can again be seen to extend across both hospitals (Table 7.14)

Table 7.14 Extent of change to level of stress experienced by hospital

Stress	Greenfield	Stockton
Greatly increased	38 (52.1%)	33 (58.9%)
Increased	31 (42.5%)	16 (28.6%)
Unchanged	4 (5.5%)	6 (10.7%)
Decreased	0	1 (1.8%)
Greatly decreased	0	0

There also appears to be consistency between the experience of doctors and of nurses (Table 7.15).

Table 7.15 Extent of change to level of stress experienced by profession

Stress	Doctors	Nurses
Greatly increased	27 (55.1%)	44 (55.0%)
Increased	17 (34.7%)	30 (37.5%)
Unchanged	4 (8.2%)	6 (7.5%)
Decreased	1 (2.0%)	0
Greatly decreased	0	0

When considering areas of work it can be seen that there is a shared experience of increased stress throughout all clinical areas (Appendix 6).

As can be seen the implementation of the NHS Reforms has had a significant and extensive impact in several areas related to the professional practice of doctors and nurses working in both hospitals, and in a variety of clinical areas. This has been an unintended consequence of the policy thrust of the Reforms, but nevertheless one which can be seen to have transformed professional practice in a way which perhaps reflects the paradox of trying to instill a market philosophy into a public service, without due consideration of the dichotomy of the underpinning value and belief systems. This, perhaps, demonstrates the importance of adopting a broad approach to policy evaluation, which seeks out these unintended consequences of policy implementation as well as investigating the stated aims of such policy.

CHAPTER 8

THE CHANGING NATURE OF PROFESSIONAL PRACTICE

Changes in the way professionals practice

Although the Delphi study had identified a change in the way that professionals practice as an important outcome of the NHS Reforms, it did not reveal the specific nature of this change, and so this was an area which was subject to an open question on the survey, and also raised in the interviews with practitioners. That significant changes had taken place became evident, although differences in the precise nature of those changes did emerge both between hospitals and between professions, as well as between clinical areas. Changes to professional practice were both positive and negative, although it is true to say that there did appear to be more negative than positive changes identified by the respondents.

It's been a very big change, my role has expanded, and I'm spending my time doing many things that I haven't had to do before. (Nurse, Stockton)

I've changed the way I work as well as the things I do. (Doctor, Stockton)

The way I work has changed, has been forced to change, by the changes that have taken place, I'm not saying that this has all been bad, in fact in some ways I feel that I am now more effective as a nurse, by becoming involved in areas other than those in which nurses were traditionally involved. (Nurse, Greenfield)

I am no longer able to function solely in the professional arena, I have had to adapt to incorporate the agendas of the managers and the politicians into my day to day work. (Doctor, Greenfield)

It was also clear that those managers responsible for the implementation of the

Reforms, also recognised at an early stage that the changes would necessitate distinct alterations in the ways in which doctors and nurses practised.

I was concerned that the clear professional lines of accountability would be lost, and that some of the strengths of professional practice, such as decision making based solely on client need, would be weakened. (Senior manager, HA)

I realised, but was not sure that the doctors and nurses always realised, that they would have to change the way that they practised, and begin to take on a much greater management role, and the responsibilities that went along with that role. (Senior manager, Greenfield)

To be honest some of the aspects of professional practice, whilst admirable, had become a bit of a luxury in a cash pressed service, and some of us could see that the Reforms would necessitate a fundamental change in the way in which doctors and nurses practised. (Senior manager, Stockton)

The answers to the question relating to the nature of changes in professional practice resulting from the Reforms were panel coded, and those which occurred most frequently (in over 15% of respondents) were subject to analysis. In all 98 respondents (76%) identified ways in which their practice had changed, citing a total of 361 examples, of which 328 were panel coded into 8 categories. 6 respondents had given two or more examples which fell into one category, and these were recorded as a single example for each of those 6 respondents.

Increased bureaucracy

This appeared in the replies of 67 (52.0%) of respondents, which is perhaps not a great surprise when considering the increased administrative workload which has already been identified. This was also an area frequently emerging during the interviews as a significant difference in professional practice in the reformed NHS.

There is an absolutely incredible amount of paperwork which we now have to do, it's bureaucracy gone mad! (Doctor, Stockton)

It's a bureaucratic nightmare, the records which we now have to keep, and the information we have to gather, to what purpose - God only knows. (Doctor, Greenfield)

I think we've become more and more like the Civil service is meant to be, everything in triplicate, and the accumulation of a wealth of useless paper and information. (Nurse, Greenfield)

I'm beginning to feel personally responsible for the demise of the Rain Forest. In the past if I needed something urgently I could ring stores and if it was in stock, a porter would bring it to the ward. Now I'm told that I must stop making these ad hoc requests, and must order everything through the ordering procedure. That's all very well, and I can see that from a financial point of view it makes sense, but after all we are looking after human beings here, and there will always be those times when we haven't been able to predict, with that sort of precision, what we will need. Last year we had an outbreak of diarrhoea on the ward and you just wouldn't believe how difficult it was to get an extra supply of incontinence pads! I'm not saying that our managers are unsympathetic, but it seems that the system is just not set up with the needs of real people in mind, because real people can't be organised, categorised and processed through the ward. (Nurse, Stockton)

Identification of an increased level of bureaucracy was greater at Greenfield where 47 (64.4%) of respondents regarded this as an important change in practice compared with 20 (35.7%) of respondents at Stockton (χ^2 9.317, p 0.005). There appears to be no statistically significant difference between professions with 24 (49.0%) doctors and 43 (53.8%) nurses citing increased bureaucracy as an area of significant change. When considering the influence of area of clinical speciality, there is a significant difference between those working in medical areas (for whom this has been a more

widely experienced practice change), and those working elsewhere (χ^2 5.577, p = 0.025).

Table 8.0 Identification of increased bureaucracy as a significant change in practice, by clinical speciality

Increased bureaucracy	Number of respondents
Medical	24 (71%)
Surgical	20 (56%)
Trauma/Orthopaedic	7 (47%)
Intensive care	4 (44%)
Theatre/Anaesthetic	5 (38%)
Paediatric	4 (27%)
Other areas	2 (33%)

During the interviews several factors emerged which support the existence of such a difference. Firstly, in relation to the apparently high level of increased bureaucracy cited by those working in medical areas, several professionals described how the increased pressure to improve patient throughput, aligned with the perceived bed shortages, resulted in them having to plan discharges for patients who still had a lot of health needs to be met, and so discharge planning had become significantly more complex and time consuming. The new community care policy discussed in Chapter 5 also resulted in an increased amount of form filling and liaison with other agencies, which had previously been far less time consuming. Medical consultants had also pointed out that many of their patients had complex health problems, and it was quite a common practice for them to have to refer patients to specialists outside their own hospital, and this was particularly problematic if it involved an extra-contractual referral, or if the patient was the patient of a GP fundholder. For those respondents

working in surgical areas, a common theme to emerge during the interviews was the bureaucracy which surrounded the creation of the internal market. Contract specifications and monitoring, extra-contractual referrals and GP fundholding were all seen to have created their own bureaucracy. The relatively low number of respondents working in paediatric areas who viewed this as an area in which they had seen significant changes in professional practice is less easy to explain, but it can be assumed that children in hospital do not bring with them the same difficulties in planning post-discharge care. As most of this will be carried out by parents, supported by the community paediatric nursing team, there is less involvement with other agencies. Also the nature of contracts for paediatric care, which are mainly block contracts, differ from the cost and volume contracts which proved to be problematic in surgical areas.

Spending less time with patients

This relates to the increased patient throughput, not necessarily to spending less of the working day with patients, which has meant that less time is spent with each individual. 60 (46.5%) respondents identified this as an important change in their professional practice. No statistically significant difference emerged between either hospital or profession. During the interviews it became obvious that this was a change in practice which, when it occurred, was generally condemned.

I have less time to spend with patients, and although I try very hard to make sure that they understand what I am telling them, I now tend to assume that when they say they understand they do, in the past I might have delved a bit more. (Doctor, Greenfield)

I think that the patients are very aware that we are rushed, I feel very guilty when I notice a patient in distress who hasn't liked to call for a nurse because we are so busy. (Nurse, Stockton)

I like to think that we do take the time to give the care needed by those whose needs are greatest, but in saying that I have to accept that the patients who

are not so dependent are often neglected, we have to prioritise, and although we've always had to do this to organise our work, in the past everyone eventually got the attention they needed, now they don't always. (Nurse, Greenfield)

I used to value the time I spent with patients, and so did they, but I am seeing many more patients now, as well as having to take on more of a managerial role, that I just don't have as much time to spend with individuals. (Doctor, Stockton)

There appears to be very little difference between the various clinical specialities in relation to this pressure on time (Table 8.1)

Table 8.1 Identification of less time available to spend with individuals as an important change in practice, by clinical speciality

Less time	Number of respondents
Medical	15 (44%)
Surgical	18 (50%)
Trauma/Orthopaedic	7 (47%)
Intensive care	4 (44%)
Theatre/Anaesthetic	7 (54%)
Paediatric	7 (47%)
Other areas	2 (33%)

Whilst it may appear that proportionately fewer respondents working in clinical areas other than those specified view this as a significant change in their practice, this can be explained by the nature of their practice, as, in the fields of radiology, pathology and out-patients, they were unlikely to have been spending lengthy periods of time with any one individual prior to the reforms, and although undoubtedly they too are seeing more patients, this does not necessarily entail a significant reduction in time spent with each because, as identified by two respondents, the organisation of services

such as these has changed dramatically, rather than the nature of the service itself.

Reduced level of support available

Experience of a reduced level of support being available was cited by 85 (38.8%) of respondents as a way in which their practice had changed. A similar experience was reported at Greenfield where 31 (42.5%) respondents gave examples in this category, and at Stockton where 19 (33.9%) respondents gave such examples. No significant difference emerged in relation to profession with 19 (38.8%) doctors and 21 (26.3%) nurses providing examples. The nature of the support which was reduced emerged during the interviews as varying most between nurses and doctors. Doctors highlighted the difficulties of providing actual clinical support for junior staff whereas nurses also identified a reduction in the level of managerial support available.

One of the effects of our need to become more efficient is that we no longer house our patients on just two wards, because of the bed shortages the patients must be placed where there is a bed available, and so we see patients being cared for by nurses who are not really experienced in that particular type of case, and that is a worry. We have always been able to rely on experienced ward sisters keeping a close eye on the junior doctors, and letting us know if they were out of their depth. We can no longer rely on that level of expertise if for instance a medical patient is on an orthopaedic ward or vice versa, and so there's no back-up system for those times when the junior staff are working alone, or at least a reduced level of back-up. (Doctor, Greenfield)

We are expected to look after patients that we are not experienced in looking after, which means that we are compromising care - having to ring other wards asking for advice, and of course we cannot always get the input that we need from them because they too are working under pressure. Sometimes, especially when I am really concerned about a patient, I feel as though there's no-one to turn to. (Nurse, Greenfield)

I can't understand that when we have so many more managers than we did

before, that they are less available to help us, and that we have to do more and more management work. (Nurse, Stockton)

More management work has been delegated to us, and although I do feel well supported by my manager, I know that is not true of all my colleagues. Although we do try to support each other when the going gets tough there is a limit to what we can do. I suppose that one of the reasons why I feel that I get enough support is that I have been around a while, and probably need less support than those who are new to the job. One thing's for sure, I wouldn't like to be a newly appointed ward sister nowadays, because I don't think that the level of support and guidance that is needed is there. (Nurse, Greenfield)

I don't like to admit it but I think that I have become one of those consultants that I used to decry for abandoning their junior staff. It's not that I don't want to teach and support my junior colleagues, but there are a limited number of hours in the day and an ever-increasing amount of work to fit into them, and that goes for the junior staff as well as for me. I know they have tried to reduce junior doctors hours, and that's good, but the work is still there, and there is only so much that we can expect the nurses to do. I often used to take one of the house officers into clinic with me to give him a chance to improve his clinical examination skills, but now we are under enormous pressure to see more patients and so I can't do anything that will slow the clinic down, even if it was a good teaching experience. (Doctor, Stockton)

When examining the issue of a reduced level of support in relation to clinical speciality, again differences do emerge (Table 8.2). There is a significant difference between those working in medical areas (for whom this has been a more widely experienced practice change), and those working elsewhere (χ^2 6.435, $p = 0.025$).

Table 8.2 Identification of a reduced level of support as an important change in practice, by clinical speciality

Reduced support	Number of respondents
Medical	17 (50%)
Surgical	12 (33%)
Trauma/Orthopaedic	3 (20%)
Intensive care	2 (22%)
Theatre/Anaesthetic	4 (31%)
Paediatric	1 (7%)
Other areas	1 (17%)

During the interviews several possible explanations for this difference were suggested. Those respondents working in medical areas frequently highlighted the problems associated with having patients cared for outside the medical wards (outliers) and the problems associated with bed shortages. All of respondents interviewed who worked within medical areas reported that they felt inadequately supported by managers when they were trying to find beds for patients, and if those beds then turned out to be in wards not designated for the care of such patients, extra difficulties arose for the doctors trying to manage those patients. Those respondents who described working within a well established team, felt supported by that team.

We keep each other going really, it's probably a bit like any crisis, it doesn't matter about status, we all muck in and help each other. I know if I've had a really bad day that the others on the ward understand, and will help out when they can. A couple of weeks ago we were really stretched, two people were off sick, and we were exceptionally busy - all having to work a lot of extra hours, well one evening when we'd worked for hours with one patient, and eventually managed to get him safely to ICU, the registrar sent out for pizzas for us all. It may seem a little thing but it showed us he had appreciated all our work, and was aware that none of us had taken a break

all day. (Nurse, Greenfield)

We've got a good team, and I feel that this is essential for good patient care, I know that the nurses will recognise if a patient is going off, they after all are more experienced than the housemen, and I know that if I'm called then I'm needed. (Doctor, Greenfield)

The low level of reduction in level of support experienced by those working in paediatric areas may well be partly explained by the fact that the team is less likely to be disrupted because paediatric patients are not cared for on adult wards, nor are adults ever placed in paediatric areas. Another factor which may be significant is the size and structure of the area's management group - clinical directorate (in the case of Stockton) or the practice management group (in the case of Greenfield). Several respondents suggested that because their particular management was so large, it was difficult to seek support and guidance over specific issues, whereas two respondents highlighted how supportive their particular, smaller, management group was, and this may go some way to explain the differences between clinical specialities. A final factor which appeared to be notable was in relation to the availability of a recognised expert, whether doctor or nurse.

Employing a nurse specialist was probably the best thing that happened for us, it's so helpful to be able to pick up the telephone and ask for advice or to bounce around ideas, it's good to know that there is someone else around. (Nurse, Greenfield)

At least now that I've been around a while I've learnt who to turn to when I need some advice or help with a patient. (Doctor, Stockton)

I work very closely with the nurse specialist, and this has allowed us to improve our services, but also has enabled us to develop a support network for the unit. (Doctor, Greenfield)

The factors which appear to have been most significant in whether or not a reduced level of support has been an important change in professional practice, are largely organisational rather than professional and as such, this reduced level of support experienced by some respondents could be argued to be a secondary rather than a primary effect of the NHS Reforms.

Greater economic awareness

It was reported by 40 (31.0%) respondents reported that the NHS Reforms had required them to develop a greater degree of economic awareness in the course of their professional practice, which had meant a significant change in the way that they practised. There was no significant difference between Greenfield where 21 (28.8%) respondents gave examples, and Stockton where 19 (33.9%) gave examples. A significant difference did emerge between professions with 10 (20.4%) doctors and 30 (37.5%) nurses giving such examples (χ^2 3.401, $p = 0.05$). This variation between doctors and nurses also emerged during the interviews, and it was suggested that it may be partly explained by the greater involvement of consultants than of clinically based nurses in management prior to the Reforms. Nurses involved in management prior to 1991 had been employed on management rather than nursing grades. So, to a large degree, even senior nurses engaged in clinical work had been protected from much of the budgetary control and financial management. The majority of the professionals surveyed and interviewed were positive about the need for a more economically aware practitioner, but several concerns were expressed about the possibility of finance rather than clinical need determining clinical management.

Looking back I have to admit that there was a lot of waste in the past, and I suppose that we never really considered the cost of the things that we used. Now, though, I have to be very aware of the cost of what I'm doing, because I have a limited budget, and when it's spent I know that I won't be given any more, so cost is one of the factors I have to think about in everything that I do, from advising on wound care to planning off duty rotas. (Nurse, Stockton)

I do worry sometimes that I consider the cost of a course of action more than perhaps I should. I know that patients would want me to decide on their treatment based on my medical knowledge rather than my financial acumen.
(Doctor, Greenfield)

I think that it is wrong to make decisions solely on cost, but I feel that this is what I am sometimes expected to do. I'm not saying that we should not be careful with our limited resources but at the end of the day I feel that the question which needs to be asked is 'Does the patient need this?' not 'Can we afford this?' and if the NHS does not have the resources to meet patients needs, then I think that this is the politician's problem not mine. (Nurse, Greenfield)

It's become very important to keep cost in mind the whole time, because if we waste resources in one area, then those resources are gone for good and are no longer available to help the patients that are still waiting for treatment. It's very easy to be emotive about the patients that are actually in our wards, but we need to keep in mind those patients who have not yet arrived at our door.
(Doctor, Stockton)

The importance of economic awareness to professional practice was also recognised by the managers.

Doctors and nurses had to get to grips with economic reality, and appreciate the importance of good budget control, and inevitably this would affect the way that they worked. (Senior manager, Greenfield)

Our professional staff could no longer go on practising in a state of disregard for cost. (Senior manager, Stockton)

The Reforms required that professional staff developed a much greater awareness of what they were doing, because prior to the need to be able to

cost services to negotiate contracts I suspect that most doctors and nurses had very little, if any, idea of how much what they were doing was actually costing. (Senior manager, HA)

When considering the importance of economic awareness as a significant change in professional practice in relation to clinical speciality (Table 8.3) no statistically significant difference is apparent.

Table 8.3 Identification of greater economic awareness as a important change in practice, by clinical speciality

Economic awareness	Number of respondents
Medical	10 (29%)
Surgical	11 (31%)
Trauma/Orthopaedic	7 (47%)
Intensive care	4 (27%)
Theatre/Anaesthetics	2 (15%)
Paediatric	4 (27%)
Other areas	2 (33%)

This was however an issue which arose during the interviews, especially in relation to those respondents working in Trauma/Orthopaedics and Intensive care. This may be partly explained by the relatively high cost of many of the resources that are utilised in these clinical specialities, and also by difficulties arising in relation to contractual arrangements.

In order to be able to give first rate emergency treatment we need to be able to access the most modern technology, and this does not come cheap, but in the long term may well mean the difference between an excellent service and a service which is just good enough. (Doctor Trauma/Orthopaedics)

Staffing costs are very high in Intensive Care, and very little can be done to reduce that - we are already cut to the bone - but there is always pressure to utilise less well qualified staff when we are trying to get bank cover, and it is often suggested that we must look for more ways to reduce our staff budget. So far we have managed to resist, but I don't know how long that will last. (Nurse Intensive Care)

I get lots of patients referred to me from outside the area, and it's become an important part of my work to be familiar with the rules governing extra-contractual referrals, because if I get it wrong then I might end up doing work for which the hospital will not be paid. (Doctor Trauma/Orthopaedic)

Last week we actually had a GP fundholder turn up on the unit to see exactly what we were doing for his patient. Now that would never have happened before GPs held their own budget. (Nurse Intensive Care)

Although greater economic awareness was not seen to be an important change in practice for those respondents working in theatre/anaesthetics (15%) this is possibly due to the fact that there had been a high level of awareness prior to the Reforms, and although processes may have changed, there has not been a significant increase in levels of economic awareness relative to the other clinical specialities.

As a theatre sister a large part of my job has always been resource management, which I don't think is true of ward sisters, they have had to become much more involved since the reforms. But from my point of view whilst there have been some changes it is more to do with accounting than actually having to take on more financial responsibility. (Nurse Theatre/Anaesthetic)

Overall there were certainly a number of accounts of how much time was spent in managing budgets, and in discussing budgets during meetings, and for a large number of respondents this relatively new aspect of their work had taken on significant

importance.

Working longer hours

This was an area of practice change identified by 39 (30.2%) respondents. There is no significant difference between Greenfield where 21 (28.8%) respondents identified this as an important change in practice, and Stockton where 18 (32.1%) respondents did likewise. During the interviews all the respondents from both hospitals felt that they were working longer hours as a direct result of the NHS Reforms, although respondents from Greenfield were more likely to perceive this as significant to their practice. There is a significant difference in relation to profession with 10 (20.4%) doctors and 29 (36.25%) nurses citing longer working hours as a significant change in the way in which they practised (χ^2 2.859, $p = 0.05$). Amongst those interviewed, whilst doctors identified that they were working longer hours the view was expressed that some of the extra time worked was necessitated more by the attempts to reduce junior doctors' hours rather than by the Reforms.

There is no doubt that we are having to work a lot more unpaid overtime, and this is due to both the increased patient throughput and dependency, and also to the increased amount of management we have had to take on. I think that the level of unpaid work carried out by people working in the NHS is the only thing which is stopping it falling apart, and that will only be for as long as people can keep it up. (Nurse, Greenfield)

I've stopped doing any private work because to be quite frank, I have neither the time nor the energy, and yet I'm starting work earlier in the morning, finishing later at night, and getting called in much more frequently when I'm on-call. (Doctor, Greenfield)

It's only Wednesday and I've already worked for 39 hours, now they only pay me for 37 1/2 hours, so effectively I'm working unpaid for the next two days. On a good week I will work 50 hours, on a bad week I lose count. I don't know how much longer I can take it, working these hours. (Nurse, Stockton)

Everybody is working longer, with the exception perhaps, of the junior doctors, but even their supposedly shorter working hours are often more myth than reality. It seems to me that it should have been obvious that we were already working flat out and that to implement these changes would stretch us to breaking point. I know that management kept telling us that we had to work smarter not harder - but that's pure bull. (Doctor, Stockton)

With two exceptions there appears to be little variation related to clinical speciality in regard to longer working hours being an important change in professional practice (Table 8.4)

Table 8.4 Identification of longer working hours as an important change in practice, by clinical speciality

Longer hours	Number of respondents
Medical	11 (32%)
Surgical	14 (39%)
Trauma/Orthopaedic	5 (33%)
Intensive care	1 (11%)
Theatre/Anaesthetic	4 (31%)
Paediatric	6 (40%)
Other areas	1 (17%)

The two areas which had a relatively low identification of longer working hours as an important change in practice were Intensive care (11%) and ‘other clinical areas’ (17%) and explanations can be found for this in the nature of the work carried out in these areas.

I know that many of the ward staff are working longer and longer days, but that is something that we cannot allow in ICU because we just cannot afford the mistakes that might happen if people are overtired, although I'm not saying that this approach doesn't sometimes give us grief. I'm very aware that the

ICU nurses have a reputation for being bolshie, but so far we have managed to stand our ground. I don't want it to sound as though I'm criticising my ward colleagues, very often they are the only trained nurse on duty, and so they may well have no way out other than to stay on duty past their time, but we are staffed in the main by trained nurses and so it is different. Also our patients are eventually transferred out of the unit, and if we are especially short staffed it is usually possible to transfer a patient out to a ward rather than having to ask someone to work on. (Nurse, Intensive Care)

In the main, at the moment, we run a nine to five service with on-call services outside of these times, so my working day is quite tightly structured, and I don't find that I am working longer hours than I did before the changes. I suppose the only real difference is that, whereas I used to be able to find time to keep myself up-to-date with what is in the professional journals during the working week, now I don't, so it's something that I have to do at home during the evenings. (Doctor, Radiology)

During the interviews it could be discerned that there were a number of concerns in relation to the lengthening working day, which perhaps explains why it was perceived by so many to be an area of important change in their professional practice.

I'm constantly tired, and now, if at the end of a shift a patient calls for attention, my heart sinks, I don't think that I have the patience that I used to, it's been worn down by so much work. (Nurse, Medical)

When, like me, you are coming towards the end of your career, it becomes harder and harder to cope with the sort of hours that are required, and more and more senior people are opting for early retirement, now while that might be jolly good thing for the individual, if it becomes widespread, the experience base of the profession is weakened. (Doctor, Medical)

Working these long hours has affected my health, my marriage and the way

in which I treat my patients. I know that if I want to consider myself, I need to get out of nursing, but when I do, I know that I will have regrets. (Nurse, Trauma/Orthopaedic)

It seems ludicrous that I continue to advise my patients on a healthy lifestyle whilst being forced into a work pattern that is far from healthy. The effect of working such long hours is that we begin to treat patients like objects instead of people, because sometimes that is the only way to get through. (Doctor, Anaesthetics)

One of my colleagues very nearly made a drug error last week, and it made me realise how easy it could be to harm a child through sheer tiredness, I know that I am not as quick thinking at the end of a long shift as I am at the beginning. (Nurse, Paediatrics)

Without exception those who had experience of longer working hours as an important change in their practice viewed this change as harmful, with negative effects both for themselves and their patients.

Low staffing levels

Another area which was deemed important in relation to the changes in practice caused by the Reforms was that categorised as low staffing levels, and 35 (27.1%) respondents identified examples of changing practice which fell into this category. No statistically significant difference emerged in relation to hospital with 24 (32.9%) respondents from Greenfield and 11 (19.6%) from Stockton identifying this as an important change in practice. Similarly there is no statistically significant difference between the professions, with 25 (31.2%) nurses and 10 (20.4%) doctors identifying this as an important change in their practice. It is interesting to note that 9 out of the 10 doctors citing examples of low staffing levels in the survey, and all the doctors interviewed who had experienced low staffing levels were referring to the staffing levels of nurses, and reported no significant changes in medical staffing levels.

We used to have 5 nurses on duty on the early shift when we had 19 beds, now we have 28 beds and only 1 extra nurse. It actually isn't possible to meet all the patients' needs with the staff available. (Nurse, Greenfield)

I can see that the nurses are really pushed, and things that need to be done just aren't, it's very difficult for us to be able to accurately prescribe intravenous fluids for our patients when the fluid balance charts are not properly completed, and yet I know how difficult it must be for the nurses to be able to do everything that needs to be done, they have to make choices, and sometimes those choices will be wrong. In effect what it means, is that with such poorly staffed wards I am now reluctant to ask the nurses to do any more than is absolutely necessary, and if, for instance a patient needs to have a daily weight recorded, then I will ask the house officer to see that it is done. Then, of course, depending on the individual, either the patient will be weighed if and when the doctor has time, or the doctor will end up in a battle with the nurses to get them to do it. Now a few years ago I wouldn't even have had to ask for daily weights to be done, Sister would have recognised that it needed to be done, and done it would be. (Doctor, Stockton)

We do our best, but more and more often our best is just not good enough, the patients we now have in our ward are all very sick, there's no such thing now as a convalescent patient in hospital, and are very dependent on nursing care, yet at the same time we have fewer trained nurses on duty, and a bigger turnover of staff, so that the nurses are less experienced. I'm ashamed to say it, but quite often our patients are frankly neglected, and that's not because of lack of knowledge or lack of skill, it's simply because of lack of nurses, and until nurses can be given an extra pair of hands, or more nurses are allocated to each ward, then patients will continue to be neglected. (Nurse, Stockton)

There are just too few nurses to deliver care to a group of patients who are increasingly dependent. This isn't satisfactory to the patients, and it's not doing any good to the nurses either because the low level of staffing is

incredible stressful. (Doctor, Greenfield)

There can be seen to be variations in the experience of low staffing levels which relate to clinical speciality (Table 8.5). There is a significant difference between those working in Intensive care, Theatre/Anaesthetics and Paediatrics (for whom this has been a more widely experienced change in practice), and those working elsewhere (χ^2 5.544, p = 0.025).

Table 8.5 Identification of low staffing levels as a significant change in practice, by clinical speciality

Low staffing levels	Number of respondents
Medical	7 (21 %)
Surgical	8 (22 %)
Trauma/Orthopaedic	3 (20 %)
Intensive care	5 (56 %)
Theatre/Anaesthetic	5 (38 %)
Paediatric	6 (40 %)
Other areas	1 (17 %)

During the interviews several factors emerged which might explain these variations. Increases in patient throughput are experienced differently, and this might go some way towards explaining the high level of examples of low staffing levels reported in Intensive care.

Because the throughput of patients has increased we are now doing far more transfers, both back to the ward and also to other hospitals, and this means that at most times during the day at least one nurse is unavailable on the unit because of coordinating a transfer. (Nurse, Intensive Care)

We always used to be able to keep a bed free in ICU so that it would be available for emergencies, now that is no longer the case, the beds are kept

full, and if an emergency arises then we have to identify a patient who is safe to transfer out. Now I know that full bed occupancy makes sense to the managers, but what they don't realise is that when we initially negotiated our staffing levels, we calculated for a less than full bed occupancy, which means that we are now short staffed in practice, but not in the managers books.
(Nurse, Intensive Care)

In paediatrics where 6 (40%) of respondents gave examples relating to low staffing levels, and theatre/anaesthetics where 5 (38%) gave similar examples, expansion of services may have more to do with the experience of low staffing levels than any increase in patient throughput.

We have developed very many new services for children and their families, and there have been some resources transferred from the hospital to the community to support this, so very often the ward staff may well be stretched. (Doctor, Paediatrics)

We have had to extend our theatre facilities to meet our contracts, for instance we now have elective lists on a Saturday, but these extended services have not been fully funded, we are expected to do just that little bit more and stretch ourselves just that little bit further, and we've about reached the limit of what we can achieve without extra staff being employed. (Nurse, Theatre)

This concern with practising in an environment which is limited in terms of human resources is again one which is viewed negatively for its effect on both the professional and the patient.

Reduced professional autonomy

Reduced professional autonomy was a practice change identified by 25 (19.4%) respondents. There was no significant difference between hospitals with 14 (19.2%) respondents from Greenfield identifying examples within this category, as compared with 11 (19.6%) from Stockton. The largest variation appeared between doctors and

nurses, with 16 (32.7%) doctors and only 9 (11.2%) of nurses identifying reduced professional autonomy as an area of important change in their professional practice (χ^2 7.618, $p = 0.005$).

Managers make decisions now, not clinicians, I am told what I can and can't do for my patients by managers with no medical knowledge whatsoever. Sometimes I think my patients might as well seek medical advice from their bank manager. (Doctor, Greenfield)

During the ward round the surgical registrar and I decided on a change of dressing for a very difficult wound. We wanted to change to a product that we both had experience of as being particularly good in that type of difficult wound. We found out from pharmacy that because it was so expensive it could only be prescribed by the consultant in very special circumstances, never matter that an experienced doctor and ward sister recommended its use. What annoys me is that it is not a matter of the consultant having the expert knowledge to decide on the use of an expensive product, this policy is used as a way of stopping us using certain things. What the managers who make these sorts of decisions just don't understand is that it is a very blinkered way of looking at managing resources, and that very often what appears to be an initial expense can turn out to be a saving if the patient can go home sooner. (Nurse, Stockton)

I just can't accept that it is right for managers to be able to tell senior consultants who they can and can't admit, surely if in my professional opinion a patient needs to be treated as a matter of urgency then I should be able to go ahead and do so, but I can't unless the managers agree - it's ridiculous! (Doctor, Stockton)

We had a patient in recently who, as he was recovering from his operation, it was found that he had another problem requiring surgery. Now in the days before the Reforms, the patient would have had his second operation while he

was in, and gone home just a couple of days later than originally expected. But because this man's GP was a fundholder he had to be contacted, and he refused outright to fund the second operation, because it turned out that he could get it done cheaper at a different hospital, and no matter what our consultant said he could not be persuaded otherwise. Now I know it wasn't a matter of life and death, but it was going to cause the patient a lot of unnecessary hassle, and I can't see why the financial considerations of the GP should have come first, the consultant decided that he needed an operation so surely he should have been allowed to do the operation. (Nurse, Greenfield)

Variations in the experience of reduced professional autonomy can be seen in relation to clinical speciality (Table 8.6), although because of small sample size statistical significance cannot be established.

Table 8.6 Identification of reduced professional autonomy as an important change in practice, by clinical speciality

Reduced professional autonomy	Number of respondents
Medical	8 (24%)
Surgical	8 (22%)
Trauma/Orthopaedic	4 (27%)
Intensive care	1 (11%)
Theatre/Anaesthetic	4 (31%)
Paediatric	0
Other areas	0

Whilst not proven to be statistically significant, the low rate of examples in this category amongst respondents working in intensive care areas is probably a reflection of the fact that the majority of this group were nurses, medical staff utilising Intensive care facilities tended to place themselves in one of the other clinical speciality categories. It is probable that for professionals working in 'other clinical areas', there have been no reported examples of experiencing reduced professional autonomy

as a way in which practice has changed because as previously identified, the major impact of the NHS Reforms for this group has been in the organisation and structure of their work rather than in care delivery itself. An explanation for professionals working in paediatric areas failing to identify reduced autonomy as a way in which their practice has changed since the implementation of the Reforms is less readily available. It would appear that they do believe that they may have had a different experience from those professionals working in adult service areas, but cannot fully account for this belief.

I think that the effect of the Reforms has been rather different in paediatrics when I listen to my friends who work on the adult wards. Our managers don't seem to interfere with what we do in quite the same way, I'm not saying that we aren't given the same sort of budget targets, but I do feel that within those targets we seem to have a bit more freedom, although I don't know why that is. (Nurse, Paediatric)

I think that management may be a bit more hesitant in involving themselves in paediatrics, now I don't know if that is, perhaps, because we have been more accepting of the Reforms than our colleagues, or that they fear the publicity more if something goes wrong with the care of a child. (Doctor, Paediatrics)

This issue of reduced professional autonomy was one which was implicitly identified as a likely effect of the implementation of the NHS Reforms by the managers.

The doctors and to a lesser degree, the nurses, had to learn to become team players, they could not continue to play their professional card when tough decisions had to be made, and they did slowly begin to realise that, if the Trust failed in any significant way, well that it was their livelihood at stake. (Senior manager, Greenfield)

I think it fair to say that there was a certain amount of distrust at the beginning. The doctors thought that as managers we would leap in and begin

to order them about, but in fact our major problem was in getting the doctors to begin to take managerial responsibility for their decisions as well as professional responsibility. I suppose, to be honest there were times when we did step in and take decisions that the doctors were unhappy about, but usually this was a situation in which we couldn't get them to make the decision. (Senior manager, Stockton)

I think that some degree of conflict was inevitable, many of the professional staff feared that the NHS Reforms posed a threat to their professional autonomy, and to be truthful I suppose that it did pose a threat to the way that they viewed their professional autonomy at that time. (Senior manager, HA)

This aspect of the changing nature of professional practice was viewed somewhat ambiguously, with clear differences emerging between doctors and nurses.

I feel very strongly that decisions which directly affect patients should be made by the consultant who is, after all, ultimately responsible for the patient. (Doctor, Stockton)

Consultants should have the final say, and it's not right, nor proper if their decisions are overturned by non-clinicians. (Doctor, Greenfield)

I know that some of the doctor's feel that they have lost some of their power because managers now have some input into decisions about service provision. I think that they were often unaware that sometimes the decisions that they made rode roughshod over the opinions of others. After all becoming a consultant was not accompanied by an instillation of wisdom, and while I agree that they should make decisions about patients, this has to be done in the context of the whole situation, and they may not have all the available information. (Nurse, Greenfield)

I think that the nurses have developed better working relations with the

managers than the doctors, who seem to see them as a threat. (Nurse, Stockton)

More patient centred approach

The final category which respondents identified as being an area of important change in their professional practice was that categorised as a more patient centred approach to care. 22 (17.1%) respondents provided examples of change which came into this category. There was a variation between hospitals with 18 (24.7%) respondents from Greenfield reporting this as an important change in their practice as compared with only 4 (7.1%) from Stockton ($\chi^2 5.734, p = 0.025$). A possible explanation for this difference is the focus which Greenfield gave to the development of patient friendly services, and the achievement of the Patient Charter standards.

In order for us to retain our contracts we saw it as vital to our survival to develop the sort of services that patients would want, because after all if a patient goes back to their fundholding GP complaining and dissatisfied, well then he is likely to take his contracts elsewhere. (Senior manager, Greenfield)

We had no choice we had to achieve the Charter standards, and we saw that as something extremely important, for after all these would be criteria by which purchasers would decide where to place their contracts. (Senior manager, Greenfield)

This approach was somewhat different to that of Stockton, who adopted a more cynical approach to the Patient's Charter standards.

I believe the Patient's charter to be a purely political document, that's what it's all about - merely ticks in boxes.....it's something that the politicians can stand up and shout about, but to my mind it's pretty meaningless, and although we do what we have to do, after all it is a political imperative, we don't see it as providing the principles by which we develop our services. (Senior manager, Stockton)

I don't think that the standards set out in the Patient's Charter are realistic, all they do is increase patients' expectations , and when they aren't met we will receive the inevitable complaint. (Doctor, Stockton)

There is no significant variation between nurses and doctors in relation to this category with 7 (14.3%) doctors and 15 (18.8%) nurses citing examples in this category. However some variation does appear in relation to area of work (Table 8.7) although again, because of small sample size statistical significance cannot be established.

Table 8.7 Identification of a more patient centred approach as an important change in practice, by clinical speciality

More patient centred	Number of respondents
Medical	6 (18%)
Surgical	6 (17%)
Trauma/Orthopaedic	5 (33%)
Intensive care	1 (11%)
Theatre/Anaesthetic	2 (15%)
Paediatric	1 (7%)
Other areas	1 (17%)

The major variation which appears in relation to clinical speciality is that 5 (33%) of professionals working in trauma/orthopaedic areas have experienced this as an area of important change in their practice, far higher than in the other clinical specialities. Many of the examples given in this category appear to be from professionals working within accident and emergency rather than in orthopaedic areas, and whilst not statistically significant this was an issue which arose during interviews.

We have come to realise that accident and emergency is the shop window of the Trust, and as such it is important to give a good impression to the people

who use the department. We have tried to make the waiting areas much more comfortable, and little things like improving the direction signs, and creating a children's play area, these have made the department much more user-friendly . To be honest I think that in the past we have organised the department to suit the staff rather than the patients, but now that we have to think about making sure we keep our contracts we have had to change our way of thinking. (Nurse, Trauma/Orthopaedics)

When we were under the threat of losing the Accident and Emergency at Greenfield it made us look at our service in a new way, what was it about us that would ensure that we survived, we couldn't cut costs any further, and we couldn't spend vast sums of money to improve services, but what we did do was to re-organise some of the things we do so that they suited the patient better. (Doctor, Trauma/Orthopaedics)

There's been a lot of work put into making our department a nicer place for the patients, and although some of the ways in which we now do things might not be as easy for us, they are better for the patient, we make a point of putting the patient first. (Nurse, Trauma/Orthopaedics)

Those who gave examples of ways in which their practice had become more patient centred viewed this as a positive change, and one which was generally welcomed.

Overall, when considering these examples of the ways in which professional practice has changed as a result of the NHS Reforms, it can be seen that such changes are widespread, and whilst differences may exist between hospitals, between professions and between clinical specialities, there can be no doubt that the Reforms of 1991 had, and continue to have, an important influence on professional practice. Such changes can be viewed both positively and negatively, but what remains unarguable is that where there is a significant change in the way that professionals carry out their professional duties, there must be some impact on the care which is received by the patient.

CHAPTER 9

THE IMPACT OF THE NHS REFORMS ON THE QUALITY OF CARE DELIVERED BY PROFESSIONALS

Overall changes to the quality of care

The Delphi study had suggested that professionals believed that the implementation of the NHS Reforms had affected the quality of care that they delivered to their clients. The extent of this belief was explored during the survey, by the use of a direct question. The specific nature of that change was investigated by way of two open questions in which the respondents were asked to give examples of improvements and deteriorations in the quality of care, and also during the course of the interviews. It became evident that quality of care was viewed as an important component of both professional practice and service delivery, by both managers and professionals.

In the early months of the changes we did think a lot about volume, and cost of course, but we also realised that we had to start to think about the quality elements, the standards of care - what sort of standards are we buying, what quality did we really want to buy? This was really where needs assessment started developing, not because of quality, but quality fed into it. As needs assessments were done so contract specifications began to be formulated, at least the broad outline, and quality very quickly became an issue, because it became obvious that there were different standards. (Senior manager, HA)

We have always focused very much on quality in our organisation, and one of the things which has been helpful is that we have had specific quality standards in our GP contracts. GP fundholders, in my opinion, have done more to improve the quality of the service in the last two years than anything else in the previous five years. We've become aware of the need to tell other people what we are doing well, and what we are really saying is that there are

times when we are better able to judge qualitatively what we are doing, than the purchaser, and it is important that we take this on board rather than merely reacting and responding to purchaser pressure. (Senior manager, Greenfield)

One of the things that I have been very unhappy about was that up until now, and I don't see any signs that it is changing, is that contracts are about money, and that's it. Not only has there been little regard to quality, the discussions on quality have been entirely separate from the contract negotiations so, if you like, it is a kind of 'add-on' which was done by more junior officers and not seen as being part of the contract discussions, which is, of course, a nonsense. (Senior manager, Greenfield)

We have a four pronged approach to quality, we are members of the King's Fund organisational audit which looks at every aspect of the organisation, including nursing, we also have a Quality of Service committee which is chaired by one of our non-executive members which holds the remit to look at all the quality indicators, but to also look at things like patient satisfaction....The third thing is our clinical audit programme, and we really are getting into clinical audit, not just medical and nursing audit. The fourth area is our Site Working Party which looks at the very tangible things, such as how user-friendly the hospital is, how accessible it is and so on. (Senior manager, Stockton)

I am quite involved with quality issues, it's something I see as being very important, and it worries me that whenever quality seems to be falling then we begin to look at it in a different way, so that the change is not so obvious. (Nurse, Greenfield)

We monitor the quality of our practice mainly by way of audit, but this doesn't tell us about every aspect of quality, for instance it takes very little notice of what the patient thinks. (Doctor, Stockton)

Sad to say there is more talk about quality of care than there is actual quality, which is fundamentally wrong, because if we can't provide quality care for our patients then we might as well go and work in Sainsburys. (Doctor, Greenfield)

I think we pay more attention to quality now than we used to, it's become more important to be able to identify what we are doing well and what must be improved. (Nurse, Stockton)

However while there does seem to be a general acceptance of the importance of quality assurance, there is not such a clear consensus as to the impact the NHS Reforms have had on the quality of care delivered by professionals (Table 9.0)

Table 9.0 Changes to the quality of care offered

Quality of care	Number of respondents
2Improved due to the Reforms	23 (19.7%)
Improved unrelated to the Reforms	17 (14.5%)
Unchanged	27 (23.1%)
Worsened due to the Reforms	45 (38.5%)
Worsened unrelated to the Reforms	5 (4.3%)

As can be seen 34.2 % of respondents answering this question believe that the quality of care that they are able to offer their patients has improved, although only 19.7% attribute this to the Reforms. Some of the other factors which may have contributed to an improved quality of care were revealed during the interviews, factors such as the increased acknowledgement of the importance of, and the availability of continuing education and advancement of medical knowledge and techniques. Several professionals also highlighted areas in which developments preceded the implementation of the Reforms.

Yes, I think I do now offer my patients better care, but I don't think it's anything to do with the Reforms, you might even say it's in spite of them. I think one of the main reasons that I have been able to improve the care I give is that recently I have been doing a degree, and that has taught me to really begin to think about what it is that I do and how I do it. There's been a lot of interest for nurses to continue their education in the past few years, and as a profession I think that we've come a long way, nurses can function much better now as a member of the multi-disciplinary team and that has certainly gone a long way to improving patient care. (Nurse, Greenfield)

There's no doubt that patients, or at least, a large number of patients are getting a better quality of care, but that's nothing to do with the Reforms, it's more to do with medical and technological developments. For instance one of the biggest improvements has been in the development of laparoscopic surgical techniques, which have shortened the length of stay and speeded up the recovery process. (Doctor, Greenfield)

Care has improved, but many of the improvements were underway before the Reforms, like our nursing development unit. (Nurse, Stockton)

42.8% of respondents believed that the quality of care they offered patients had worsened, and of these only 4.3% felt that this deterioration was unrelated to the Reforms. During the interviews, factors other than the Reforms which may have had an influence on a worsening quality of care were not explicitly identified, although several professionals did suggest that our increasing expectations and those of our patients were not the product of the Reforms, and that often when the quality of care was perceived to be worsening, it was more a matter of new expectations being unmet.

I'm not saying that sometimes care isn't poor, but it could be that we are unrealistic as to what is possible, and I don't think that this is the fault of the Reforms, it's probably just human nature. (Nurse, Stockton)

When comparing responses from the two hospitals differences can be identified, although because of the small sample size, they are not statistically significant (Table 9.1)

Table 9.1 Changes to the quality of care offered, by hospital

Quality of care	Greenfield	Stockton
Improved due to Reforms	14 (20.6%)	9 (18.4%)
Improved unrelated to Reforms	12 (17.6%)	5 (10.2%)
Unchanged	18 (26.5%)	9 (18.4%)
Worsened due to Reforms	21 (30.9%)	24 (49.0%)
Worsened unrelated to reforms	3 (4.4%)	2 (4.1%)

Whereas 38.2% of respondents from Greenfield felt that the quality of care they offer has been improved, and 20.6% attributing this to the Reforms, only 28.6% of respondents from Stockton claim an improved quality of care, with 18.4% attributing this to the Reforms. As can be seen the greatest variation is in those respondents who believe that improvements in the quality of care are unrelated to the Reforms, with 17.7% from Greenfield believing this to be the case, as compared with 10.2% from Stockton.

What did become evident during the interviews was a different culture between the two hospitals, especially in relation to interprofessional collaboration between nurses and doctors. It would appear that the strong working relationships which had developed at Greenfield created the environment in which such quality developments could flourish, although both nurses and doctors believed this to still be at an early stage.

I like to think that the old doctor-nurse hierarchy has broken down, we work as a team and we each learn from each other. We've seen a lot of good ideas coming from the nurses as to how we can develop our services, and they work very well in the Practice Management Group. I think that we have under-

utilised the skills of nurses in the past, and there is a lot of scope for them in the future. (Doctor, Greenfield)

At this hospital the doctors and nurses work as a team, it's not like other hospitals I've worked at where it's a them and us sort of relationship. We all pull together and although we have our disagreements at times, we are all working towards the best care for our patients. (Nurse, Greenfield)

There are still a lot of ways in which the care we give to patients could be improved, and not all of those will cost a great deal of money, and I suppose that as a team we will continue to look for ways that we can deliver better care, not only us nurses, but the doctors and physios are all involved. (Nurse, Greenfield)

This type of collaborative care culture was one which did not emerge as a significant issue in the interviews with professionals from Stockton, and may have provided at least a partial explanation for the variations identified. When considering the responses between professions less variation can be seen (Table 9.2)

Table 9.2 Changes to the quality of care offered, by profession

Quality of care	Doctors	Nurses
Improved due to Reforms	10 (21.3%)	13 (18.6%)
Improved unrelated to Reforms	5 (10.6%)	12 (17.1%)
Unchanged	14 (29.8%)	13 (18.6%)
Worsened due to Reforms	16 (34.0%)	29 (41.4%)
Worsened unrelated to Reforms	2 (4.3%)	3 (4.3%)

Doctors and nurses are very close in the proportion of respondents who believe that the quality of care has improved with 31.9% of the doctors who responded to this

question, and 35.7% of the nurses, who believe this to be the case. A higher proportion of doctors (29.8%) believe that quality of care is unchanged than do nurses (18.6%) a percentage differential of 11.2 There is a smaller differential (7.4) in the percentage of those who believe the quality of care to have worsened, with 38.3% of doctors and 45.7% of nurses holding this opinion.

The biggest variation in the quality of care relating to the impact of the NHS Reforms can be seen when examining responses by areas of work (Appendix 7, summarised in Table 9.3)

Table 9.3 Summary of work area statistics on changes to quality of care offered

Quality	Minimum %	Maximum %	Range %	Mean %	Standard Deviation
Improved	17.6	51.6	35.0	34.6	11.1
Worsened	20	55.9	26.9	37.1	15.01

It is evident that the work area is the variable most closely related to the improvement or worsening of the quality of care offered by respondents. The most positive picture of improved quality of care is presented by those respondents working in medical areas, 51.6% of those responding to this question believing that the quality of care has improved, and only 35.5% believing that care has worsened. At the opposite end of the scale the most negative picture of quality of care is presented by those respondents working in surgical areas of whom 55.9% believe that the quality of care has worsened, and only 17.7% that it has improved.

During the interviews several professionals suggested explanations for the apparent difficulties in maintaining quality of care within surgical areas.

Of course, the Reforms have had the most impact on surgical services, we have been the hardest hit. The main reason for this is that is the type of cost and volume contracts that we have negotiated. We were really negotiating in

the dark because whatever they say about needs assessment, the need for medical services is not that predictable. Now what happens is that we base our contracts on the level of work that we have done previously, but other things changed that prevented us from doing what we had done before.....there was a massive increase in emergency cases, and also we were getting more and more medical patients housed on our wards, because elderly care services had contracted. So of course we struggle to meet our contracts, there's a lot of pressure on us, but when push comes to shove then emergency cases will be given priority over patients coming in for elective surgery. (Doctor, Greenfield)

It's a nightmare in the surgical wards, we are overflowing with medical patients because they don't have enough beds, we seem to be getting more and more emergencies coming in, and then we get blamed for not completing our contracts, but we just can't do it all, at least not properly. ' (Nurse, Stockton)

The type of surgical patients have changed, they are much more dependent, many of them are really very heavy nursing problems, yet there is all this pressure to move people through quickly so that we can meet our contracts. Friends of mine who work on the medical wards don't seem to be getting this extra pressure to meet throughput targets. ' (Nurse, Greenfield)

We are the victims of reactive management in the surgical directorate, they close beds because money is tight, we can't get our elective cases through, they fear that contract money will be lost, so extra beds are opened to deal with the long waits. I feel like I'm on a roundabout, and the patients are just not getting the care that they need, when they are cared for on wards which are staffed by inexperienced nurses, or rather nurses who are experienced in a different field of practice. (Doctor, Stockton)

Improvements in the quality of care offered by professionals

Although the response to the direct survey question revealed the perception of the

direction of changes to quality of care offered by professionals, it could not identify the specific nature of quality changes, and so respondents were asked to specify examples of improvements and deteriorations in the quality of care that they offered to their patients which could be directly attributed to the Reforms. The opportunity to complete this section of the questionnaire was taken by 88 (68.2%) respondents. However, this included 35 respondents (27.1%) who did not offer any examples but stated that there were no examples of improvements in the quality of care which could be attributed to the Reforms. There was no significant difference between hospitals in relation to those believing there to have been no improvement with 21 (28.8%) respondents from Greenfield and 14 (25%) from Stockton holding this opinion. Similarly there is no statistical significance between professions with 15 (30.6%) doctors and 20 (25%) nurses believing there to have been no quality improvements; and no difference which relates to clinical speciality (Table 9.4).

Table 9.4 Respondents explicitly identifying no quality improvements due to the Reforms, by clinical speciality

No quality improvements	Number of respondents
Medical	10 (29%)
Surgical	10 (28%)
Trauma/Orthopaedic	4 (27%)
Intensive care	2 (22%)
Theatre/Anaesthetic	4 (31%)
Paediatric	3 (20%)
Other clinical areas	2 (33%)

The remaining 53 respondents who completed this section gave 184 examples of improved quality of care offered to their patients (averaging 3.5 examples per respondent) These were panel coded and seven categories of quality improvement were identified. There were 13 instances when respondents gave two or more examples which fell into the same category and all but one of these were disregarded for this stage of the analysis. Thus the categorisation is by respondents who gave one

or more examples rather than of examples per se. This left 171 examples of improved quality in the seven categories:

- (1) Improved organisation.
- (2) Expanded range of services.
- (3) Patient-focused care.
- (4) Resource management.
- (5) Patient information
- (6) Clinical audit.
- (7) Community liaison.

Improved organisation

In this category 52 (40.3%) respondents gave examples. There was no significant difference between Greenfield where 28 (38.4%) respondents provided such examples, and Stockton where 24 (42.8%) gave such examples. Similarly no difference emerges between professions with 18 (36.7%) doctors and 34 (42.5%) nurses identifying examples whereby improved organisation represented an improvement to the quality of care. A diversity of examples were submitted which fall into this category.

We have a computer system which allows us to access lab results much more quickly, and so start treatment sooner than we could before.

Admissions are centralised, so that we can find out very quickly bed availability should we need to admit a patient.

The expansion of day care services has allowed us to become much more organised in planning patient care.

The development of a one stop clinic will be a real boon to breast care patients as well as being more cost-effective.

Pre-admission clinics have been a big improvement for patients as well as

reducing the in-patient stay.

We now offer a same day results service for GPs.

There is no statistically significant difference between clinical specialities in the frequency with which this category appears in the responses (Table 9.5).

Table 9.5 Improved organisation identified as a quality improvement, by clinical speciality

Improved Organisation	Number of respondents
Medical	13 (38%)
Surgical	18 (50%)
Trauma/Orthopaedic	6 (40%)
Intensive care	5 (56%)
Theatre/Anaesthetic	3 (23%)
Paediatric	5 (33%)
Other clinical areas	2 (33%)

Improved organisation, whilst not without difficulties in some areas, has been viewed as a positive change in many cases, which has been viewed as instrumental in improving the quality of care.

In the Health Service we are well accustomed to change and reorganisation, I think what has been different this time is that we, as service providers, have been allowed to re-organise our own departments, within limits of course, to meet the needs of our client group. This has meant that the people responsible for the reorganisation have been the ones who were best placed to identify problems and suggest solutions, and so we have been able to improve the quality of care. (Doctor, Surgical)

I think that we are much more efficient now, because we are more aware of

the need to be better organised and to avoid waste, and this has definitely improved the service to the patients. (Nurse, Medical)

We have had to radically change the way that we do things, and that has been painful at times because the way we organised things before was comfortable for us if not for the patients! (Nurse, Trauma/Orthopaedic)

Expanded range of services

In this category 34 (26.4%) respondents gave examples of improvements in the quality of care they could offer which related to an expanded range of services available for the patients. There was no significant difference between hospitals, with 18 (24.7%) respondents from Greenfield, and 16 (28.6%) from Stockton giving examples which came into this category. When considering this category in relation to profession, again there is no statistically significant difference with 12 (24.5%) doctors and 22 (27.5%) nurses citing examples of expansion in the range of services available improving the quality of care that they were able to offer.

The opening of a new Diabetic centre.

An improved range of diagnostic facilities.

Drop-in clinic for same day referrals.

Much greater range of cardiology investigations available on-site.

Better availability of link workers to translate.

Establishment of a joint dialysis unit.

Wider range of day care services.

A discharge suite has been set up.

When considering this area of quality improvement in relation to work areas, again no statistically significant differences can be seen (Table 9.6).

Table 9.6 Expanded range of service provision identified as a quality improvement, by clinical speciality

Expanded range of services	Number of respondents
Medical	11 (32 %)
Surgical	9 (25 %)
Trauma/Orthopaedic	2 (13 %)
Intensive care	3 (33 %)
Theatre/Anaesthetic	4 (31 %)
Paediatric	3 (20 %)
Other areas	2 (33 %)

Explanations for the relatively low number of examples given in this category for respondents working in trauma/orthopaedic and intensive care areas, are not easily determined, although some possible reasons which might provide a partial explanation, did emerge during the interviews. However, as this difference cannot be statistically verified, it may be no more than chance.

I can see that there has been quite a lot of money spent in developing certain services, but in a sense, we are fairly marginalised from these, and don't benefit as much as some of the wards. (Nurse, Intensive care)

We still have great problems in finding beds for patients in A & E, and while the expansion of day care services has helped many people, it doesn't help us with our main problem - bed shortages. (Doctor, Trauma/Orthopaedic)

Patient focused care

In relation to patient focused care 23 (17.8%) respondents identified quality

improvements in this area. These improvements were diverse, but the common factor was that the care offered by the professional was better focused towards the patients needs.

Integrated clinics have reduced the number of times that patients have to visit the hospital.

Advanced skills training for nurses is both cheaper for the hospital and better for the patient.

Saturday morning operating lists for day care patients is very helpful for those who need to arrange child care.

Planned early discharges.

There is no significant difference appearing between hospitals with 12 (16.4%) respondents from Greenfield, and 11 (19.6%) from Stockton giving examples which came into this category. This was however, an area of apparent difference between professions during the interviews, although not statistically significant, with 17 (21.2%) nurses, and 6 (12.2%) doctors giving examples of improved quality in this category. Whilst the reasons for any differences between the professions are likely to be multi-factorial, they are presumably related to the expanded role of many nurses which can be seen as a secondary effect of the Reforms, in that the drive for efficiency revealed an under utilisation of the skills of experienced nurses.

We realise now that we had failed to fully use the array of skills that our senior nurses had developed, and it was only through our need to improve our efficiency, that we really began to address this. We now offer our senior nurses advanced skills training, which allows them to take on a number of tasks which would previously been undertaken by doctors, and of course, this means that patients get the care they need when they need it, rather than having to wait for a doctor to become available. (Senior manager, Stockton)

In the past nurses have been held back, and not encouraged to do what they knew that they were capable of, and I think that as the managers have become more and more conscious of cost, then they began to realise that there were a number of things that nurses could do perfectly well, and at the same time improve the service to the patients. (Nurse, Greenfield)

Nurses are recognised as having a major role to play in the development of services in the future, and in ensuring the provision of quality within those services. Our progress towards providing the most cost effective service relies heavily on developing the skills of nurses. (Senior manager, Greenfield)

Nurses now carry a lot of responsibility for areas that used to be part of the doctor’s work, and I am sure that this will continue to develop, because nurses are the people who are in most constant contact with the patient, and it is better for them if nurses can carry out as much of their care as possible. (Nurse, Greenfield)

Differences emerged in this category in relation to work area (Table 9.7) although, again, these cannot be proven to be statistically significant due to the small sample size. This was not an area of quality improvement which emerged during the interviews as being particularly related to clinical speciality.

Table 9.7 Patient focused care identified as a quality improvement, by clinical speciality

Patient focused care	Number of respondents
Medical	6 (18%)
Surgical	4 (11%)
Trauma/Orthopaedic	4 (27%)
Intensive care	3 (33%)
Theatre/Anaesthetic	1 (8%)
Paediatric	4 (27%)
Other areas	1 (17%)

Resource management

Another category to emerge in relation to quality improvements was that of resource management, with 21 (16.3%) respondents giving examples which came into this grouping.

Resource management at departmental level, or even ward level, allows the use of resources to best meet the patient's needs.

Changing duty rotas to provide better ward cover.

Controlling our own budget - we can spend on what is really needed.

Being able to allocate our resources where they are needed.

A statistically significant difference did not emerge between the hospitals, with 9 (12.3%) respondents from Greenfield, and 12 (21.4%) from Stockton giving examples in this category. Any apparent difference may well be explained by the fact that budgets had been devolved much earlier at Greenfield than at Stockton, and so examples of improvements in quality of care within this category, may have been less likely to be attributed to the Reforms at Greenfield than at Stockton. Similarly, no significant difference could be related to profession with 16 (20.0%) nurses and 5 (10.2%) doctors providing examples within this category. Any apparent difference is likely to be a reflection of the greater involvement that consultants had with budget management prior to the Reforms than did nurses. When considering the influence of clinical speciality (Table 9.8), there is a significant difference between those working in Medical, Trauma/Orthopaedic, Paediatric and Other areas (for whom this is a more widely experienced area of quality improvement), and those working elsewhere (χ^2 9.672, $p = 0.005$). These differences are likely to be related to the level of involvement with financial issues prior to the Reforms, with respondents identifying quality improvements with resource management, being those who had experienced responsibility for resource management as a direct effect of the Reforms.

Table 9.8 Identification of resource management as a quality improvement, by clinical speciality

Resource management	Number of respondents
Medical	7 (21%)
Surgical	3 (8%)
Trauma/Orthopaedic	5 (33%)
Intensive care	0
Theatre/Anaesthetics	0
Paediatric	4 (27%)
Other areas	2 (33%)

It is arguable whether the quality improvements identified as being due to resource management can be directly attributable to the NHS Reforms, or would have occurred as a natural consequence of the drive towards resource management of the 1980s. However what is evident is that the Reforms gave the necessary impetus to extend and improve existing resource management schemes.

Until the Reforms were implemented, there was, if you like, lip service paid to the idea of resource management in any real sense. What the Reforms have done is to bring resource management to where it should be - at the sharp face of care delivery. (Senior manager, Stockton)

Of course I'd heard of resource management, but it only became a reality as we began to relate it to our contracts, and began to plan how we could service those contracts. (Nurse, Greenfield)

Patient information

Examples which fell into this category were given by 16 (12.4%) respondents. There was no significant difference between hospitals with 10 (13.7%) respondents from Greenfield and 6 (10.7%) from Stockton giving examples which came into this category. Differences between the professions cannot be statistically demonstrated with 12 (15.0%) nurses and 4 (8.2%) doctors giving examples in this category.

More information sheets available about various investigations.

Better pre-admission information.

Clearer instruction leaflets, in more languages.

More written information available, which is better produced.

Apparent differences, although not statistically significant, emerged between respondents working in Medical, Intensive Care and Other clinical areas (who experienced quality improvements in this category more widely) and those working in other areas. Differences in this category relating to work areas (Table 9.9) can be associated with particular projects which had taken place.

We have spent a lot of time trying to produce information for patients and relatives, because we know that admission to ICU is very stressful, and now that patients are likely to spend less time with us, it is important that we get this information across as effectively as possible. (Nurse Intensive care)

Many of our patients have to undergo a variety of investigations, and so we have worked with our colleagues in the X-ray department to improve our range of information sheets. Because we have to get patients in and out so quickly we have had to use a lot more written information than we did in the past, and I think that this has been very helpful for the patients. (Doctor Medical)

Table 9.9 Patient information identified as a quality improvement, by clinical speciality

Patient information	Number of respondents
Medical	7 (21%)
Surgical	3 (8%)
Trauma/Orthopaedic	1 (7%)
Intensive care	2 (22%)
Theatre/Anaesthetic	1 (8%)
Paediatric	1 (7%)
Other areas	1 (17%)

Clinical audit

Clinical audit was identified as having been an area of quality improvement by 13 (10.1%) respondents.

Clinical audit - we have identified areas where improvements are needed.

Auditing our practice has alerted us to any problems far earlier than before.

Audit helps us to identify what works and what doesn't

There was no significant difference between hospitals, with 8 (11.0%) respondents from Greenfield and 5 (8.9%) from Stockton giving examples which came into his category. There is a more apparent difference between professions, although not statistically significant, with 10 (12.5%) nurses as compared to 3 (6.1%) of doctors giving examples in this area. A possible explanation for this apparent difference emerged during the interviews.

Clinical audit has replaced our old M & M (Mortality and Morbidity) meetings, which were seen as somewhat punitive by many doctors, and I think that they still view the audit process in this light. (Doctor, Greenfield)

In my opinion nurses are far more open to the possibilities of clinical audit, many of the doctors are wary, but nurses see it far more as a way of enhancing their practice. (Nurse, Stockton)

Differences between work areas (Table 9.10) cannot be so easily explained, and it is possible that the apparent differences are no more than chance, although it is likely that those respondents who are new to the process of clinical audit are more able to see the actual and potential benefits in relation to the quality of patient care.

Table 9.10 Identification of clinical audit as a quality improvement, by clinical speciality

Clinical audit	Number of respondents
Medical	4 (12%)
Surgical	2 (6%)
Trauma/Orthopaedic	3 (20%)
Intensive care	1 (11%)
Theatre/Anaesthetics	1 (8%)
Paediatric	2 (13%)
Other areas	0

Again this is an area which was under development prior to the implementation of the NHS Reforms, the major effect of the Reforms being to integrate the variety of audit processes being undertaken to an over-arching process of clinical audit. However, the perception of those interviewed was that the Reforms had fostered the development of audit, and that without the Reforms, it may have remained under-developed.

Before the Reforms we played at audit, but now it's necessary to survive, we must be able to identify what it is that we are doing and what we need to improve on, in order to retain our contracts. (Senior manager, Stockton)

I believe that without the Reforms we would not have developed clinical audit in the way we have. Although, no doubt, it was seen as useful before, there was no force to improve or further develop it, and it probably wouldn't have been. (Doctor, Greenfield)

Community liaison

The final category identified in relation to quality improvement was that of community liaison of which 12 (9.3%) respondents provided examples.

Better communication with GPs has resulted in a better service for patients.

We communicate better with those who will be giving post-discharge care.

There is more liaison between hospital and community.

More information is passed from community to hospital and vice versa, so that time is not wasted collecting information that is already available elsewhere.

Within this category there is again no significant difference between hospitals with 7 (9.6%) respondents from Greenfield and 5 (8.9%) from Stockton giving examples in this category. This is also true when considering professions with 5 (10.2%) doctors and 7 (8.8%) nurses giving similar examples. Variations do appear in relation to work area (Table 9.11) which, although not statistically significant, might reflect, with perhaps the exception of surgical areas, the differing levels of community liaison necessitated by the nature of the work undertaken.

There is no apparent explanation for the relatively low identification of community liaison as a quality improvement by those respondents working within surgical areas, although it is possibly related to the level of community liaison which was undertaken prior to the implementation of the Reforms.

Table 9.11 Identification of community liaison as a quality improvement, by clinical speciality

Community liaison	Number of respondents
Medical	6 (18%)
Surgical	1 (3%)
Trauma/Orthopaedic	2 (13%)
Intensive care	1 (11%)
Theatre/Anaesthetics	0
Paediatric	2 (13%)
Other areas	0

Deteriorations in the quality of care

In response to the open question requesting examples of deteriorations in quality of care directly attributable to the NHS Reforms 92 (71.3%) took the opportunity to offer 424 examples (averaging 4.6 per respondent). When these answers were panel coded eight categories of quality deterioration were identified. There were 32 respondents who gave two or more examples which came into the same category, and for this stage of the analysis all but one of these were disregarded. Thus the categorisation is by respondents who gave one or more examples rather than of examples per se. This left 361 examples in the eight categories:

- (1) Time limitations.
- (2) Access to services.
- (3) Staffing levels.
- (4) Skill mix.
- (5) Continuity of care.
- (6) Inequalities.
- (7) Cancellations and delays.
- (8) Premature discharge.

Time limitations

The area of deterioration in the quality of care which appeared most frequently was

that which was classified as time limitation, and 67 (51.9%) respondents gave examples which were included in this category.

I no longer have enough time to give patients adequate counselling.

Patients have died alone because there is no time to be with them.

There is not enough time available to feed patients properly.

The amount of time available to see each patient in clinic is too short.

There is no time to be able to just stop and listen.

There is not enough time to help patients cope with their fears.

We just don't have the time to do everything that the patients need

If you ask me the one thing that would improve patient care more than anything else, it would be if we had more time

There is never enough time, never.

This category can be seen to relate closely to two of the important changes in professional practice identified in Chapter 8, first to the increased workload and secondly to a reduction in staffing levels, both changes which limit the amount of time available for individual patients. A significant difference can be seen between hospitals in relation to this area with 44 (60.3%) respondents from Greenfield, as compared with 23 (41.1%) from Stockton giving examples in this category (χ^2 4.037, $p = 0.025$). This finding may well be closely related to the relative (rather than absolute) fall in staffing levels experienced at Greenfield, which has been previously identified. When considering this area in relation to profession a significant difference can be identified. Examples are given by 18 (36.7%) doctors and 49

(61.2%) nurses (χ^2 6.637, $p = 0.005$). This greater incidence of examples from nurses can be seen to relate to their greater experience of reduced staffing levels. Less variation can be seen when considering this area in relation to work area (Table 9.12)

Table 9.12 Identification of time limitation as a quality deterioration, by clinical speciality

Time limitations	Number of respondents
Medical	21 (62%)
Surgical	18 (50%)
Trauma/Orthopaedics	8 (53%)
Intensive care	6 (67%)
Theatre/Anaesthetics	7 (54%)
Paediatric	6 (40%)
Other areas	1 (17%)

The greatest variation which appears in the low level of examples reported in this area by respondents working in other clinical areas can be explained by the different nature of their work.

Access

The second most frequently reported area of quality deterioration was that of access, 58 (45%) of respondents giving examples which came into this category.

Access to specialist services is much poorer.

Access to services outside of the Trust is almost impossible.

Referrals take very much longer.

Convalescence is no longer provided.

There is a long wait for some services.

No statistically significant difference exists between hospitals, with 36 (49.3%) respondents from Greenfield, and 22 (39.3%) from Stockton giving examples in this area. Neither is there any significant difference between professions, with 23 (46.9%) doctors and 35 (43.8%) nurses giving examples in this category. There can, however, be seen to be a significant difference between those respondents working in Medical, Surgical and Trauma/Orthopaedic areas (who experience access as a quality deterioration more widely) and those working elsewhere (χ^2 9.009, $p = 0.005$)

Table 9.13 Identification of access as a quality deterioration, by clinical speciality

Access	Number of respondents
Medical	19 (56%)
Surgical	20 (56%)
Trauma/Orthopaedic	8 (53%)
Intensive care	2 (22%)
Theatre/Anaesthetic	4 (31%)
Paediatric	4 (27%)
Other areas	1 (17%)

In relation to the three areas in which access could be seen to be a particular problem - medical, surgical and trauma/orthopaedics, the same explanation could be seen to recur.

There are virtually no long stay beds available now, and community care is not always appropriate, for various reasons, and it can take months to arrange residential or nursing home care, which of course means we have a bed which is blocked. (Nurse, Medical)

The medical wards are always blocked, we get their overspill, and so can't

admit patients who require surgical treatment. (Doctor, Surgical)

Many of our patients need very lengthy rehabilitation, especially if they are elderly, but there just isn't the availability of medium and long term beds any more, it's a case of being in an acute ward or being sent home, and so we always have a number of long term patients who don't really require hospital care but who aren't well enough to go home, and are not candidates for a nursing home. (Nurse, Trauma/Orthopaedic)

In my opinion one of the most short-sighted moves ever was the massive reduction in long-term care for older people. Many of our patients are just not suitable for so-called community care, and so they end up staying for some considerable time, in an equally unsuitable acute hospital bed. (Doctor, Medical)

Every week it's the same, having to juggle the elective admissions because we have beds blocked by long-term patients with nowhere to go. (Nurse, Surgical)

There are two issues relating to access which can be seen to arise here, firstly access to non-acute services, and secondly denial of access because of inappropriate use of acute facilities.

Staffing levels

Again this was an area which was exposed as a significant change in professional practice, only to re-emerge as an area of quality deterioration. 54 (41.9%) respondents offered examples of quality deterioration in this category.

Patients are having to wait longer for a nurse because there are fewer nurses available.

Less nurses - more post-operative complications.

Medications are often late because there are not enough nurses.

There are too few nurses to be able to prevent pressure sores.

There are never enough nurses to allow one to come on the ward round, so they often are unclear as to changes in treatment.

As in relation to reduced staffing levels as a change in practice, some variation appeared in relation to hospital which was not statistically significant, with 34 (46.6%) respondents from Greenfield and 20 (35.7%) from Stockton giving examples. The difference between professions however, did prove to be significant with 9 (18.4%) doctors and 45 (56.3%) nurses doing likewise (χ^2 16.396, $p = 0.0005$). Explanations for these differences which appear in relation to quality deterioration in the category of staffing levels are likely to mirror those for the differences in perception of reduced staffing levels as a significant change in professional practice. Different views between reduced staffing levels as an important practice change (Table 8.5), and staffing levels as a category of quality deterioration (Table 9.14), do appear to be related to work areas. Those respondents working in Trauma/Orthopaedics were more likely than colleagues working elsewhere to experience quality deteriorations in this area (χ^2 5.388, $p = 0.25$)

Table 9.14 Identification of staffing levels as a quality deterioration, by clinical speciality

Staffing levels	Number of respondents
Medical	12 (35%)
Surgical	15 (42%)
Trauma/Orthopaedic	11 (73%)
Intensive care	5 (56%)
Theatre/Anaesthetic	4 (31%)
Paediatric	5 (33%)
Other areas	2 (33%)

It appears that the impact of reductions in staffing levels is not consistent in its effects and in some work areas the effect on the quality of care may well be more marked than in others.

Skill mix

An area which is closely linked to, yet distinct from staffing levels, is that of skill mix, a category in which 44 (34.1%) respondents provided examples of deterioration in quality of care.

Untrained staff are delivering more and more direct care, for which they lack skill.

Even when well supervised, health care assistants cannot be expected to carry out care as skilfully as a trained nurse.

Lack of experience means slower identification of problems.

Inexperienced staff are unable to respond as appropriately in an emergency.

Poor skill mix means poorer care.

Respondents highlighted two areas in relation to skill mix: the higher proportion of untrained staff; and the inexperience of many staff. Little difference can be seen between hospitals, with 27 (37.0%) respondents from Greenfield, and 17 (30.4%) from Stockton citing examples of quality deterioration in this category. The difference is significant when considering profession, with 36 (45.0%) nurses, compared to only 8 (16.3%) doctors offering examples (χ^2 9.877, $p = 0.005$) It is interesting to note that the examples given by doctors relate to the skill mix of nurses, as this appears to be an area of change which has been largely confined to nurses, although of course affecting the work of doctors.

Table 9.15 Identification of skill mix as a quality deterioration, by clinical speciality

Skill mix	Number of respondents
Medical	8 (24%)
Surgical	12 (33%)
Trauma/Orthopaedic	9 (60%)
Intensive care	3 (33%)
Theatre/Anaesthetic	5 (38%)
Paediatric	5 (33%)
Other areas	2 (33%)

In relation to work areas (table 9.15) a significant difference emerges in relation to the high number reported by respondents working in trauma/orthopaedic areas who were more likely to experience quality deteriorations in this area than were their colleagues working in other clinical specialities (χ^2 3.744, $p = 0.05$). There has been no clear explanation emerging during the interviews to account for this difference.

Continuity of care

41 (31.8%) respondents reported examples of quality deterioration in this category.

Moving patients from ward to ward as beds become available means that continuity of care is non-existent.

High usage of bank and agency staff means that care is fragmented.

Community care is a joke, patients don't get their care continued at home and more and more of them end up being re-admitted.

Care is prioritized on a day to day basis, and so is no longer consistent.

An apparent difference, which was not statistically significant, did emerge between

hospitals with 26 (35.6%) respondents from Greenfield, compared to 15 (26.8%) from Stockton giving examples in this category. During the interviews possible explanations for this apparent difference did emerge.

One of the biggest changes that I have had to learn to live with is that I no longer have all my patients within two wards. They are now scattered all over the hospital, and may well be moved several times during their stay. This makes a nonsense of the idea of continuity of care. One patient may have had three or four teams of nurses looking after them during a one week stay.
(Doctor, Greenfield)

Although we end up looking after all sorts of patients, we do tend to keep them on the ward once they've arrived. There doesn't seem much point to keep moving them around, unless there's a very good reason. (Nurse, Stockton)

It would appear that at Greenfield more attempt is made to place patients in the specialist ward as soon as possible after their admission, whilst this does not seem to be such an issue at Stockton. This may explain why quality deteriorations relating to this area may be more prominent at Greenfield. When examining this area in relation to professions, there is no significant difference, with 15 (30.6%) doctors and 26 (32.5%) nurses giving examples in this category. Some variations can be seen in relation to clinical speciality (Table 9.16), although these are not statistically significant.

The low level of examples given by respondents working in intensive care, theatre/anaesthetic and other clinical areas can be explained by the nature of the work that is undertaken in these areas, these categories being those which undertake what can be termed transitional care, from which transfer or return to other wards is expected. Similarly in paediatric areas, there is no cross-over with adult services, and children are cared for solely within the paediatric unit, so the problems which occur due to ward transfers do not arise. Overall quality deterioration related to continuity of care is of a different nature within the different work areas.

Table 9.16 Identification of continuity of care as a quality deterioration, by clinical speciality

Continuity of care	Number of respondents
Medical	11 (32%)
Surgical	15 (42%)
Trauma/Orthopaedic	5 (33%)
Intensive care	1 (11%)
Theatre/Anaesthetic	3 (23%)
Paediatric	3 (20%)
Other areas	1 (17%)

Inequalities

39 (30.2%) respondents gave examples which relate to the exacerbation of inequalities in care provision, although these were of a diverse nature.

Patients of GP fundholders get preferential treatment.

Less services are available for old people.

Patients who go to A & E rather than their GP often manage to speed up their admission.

Patients who complain the loudest get the quickest treatment.

Patients who have been on the list longest get their treatment before those who may need it more.

There is little difference between hospitals in relation to the percentage of respondents giving examples falling within this category, with 23 (31.5%) respondents from Greenfield, and 16 (28.6%) from Stockton citing examples of quality deterioration which relate to the worsening of inequalities. Also little difference between

professions can be seen with 16 (32.7%) doctors, and 22 (27.5%) nurses giving similar examples. When considering clinical speciality (Table 9.17) a significant difference emerges in relation to those respondents working in medical areas (who have a wider experience of quality deterioration in this area) compared to those working in other clinical areas (χ^2 5.044, $p = 0.025$).

Table 9.17 Identification of inequality as a quality deterioration, by clinical speciality

Inequalities	Number of respondents
Medical	16 (47%)
Surgical	12 (33%)
Trauma/Orthopaedic	5 (33%)
Intensive care	2 (22%)
Theatre/Anaesthetic	1 (8%)
Paediatric	2 (13%)
Other areas	1 (17%)

Other variations in relation to clinical speciality can be identified, but statistical significance cannot be established. It is likely that in relation to respondents working within theatre/anaesthetics and other clinical areas, any changes in quality in relation to the existence of inequalities may remain hidden, as when professionals come into contact with clients in theses areas, the decision to treat, or at least to pursue investigations has already been made, and so the time at which inequality is most likely to occur comes prior to their interaction with the client. The two examples of quality deterioration in relation to inequalities which were offered by respondents working within paediatric areas both related to the ability of GP fundholders to obtain quicker referral to specialist services which required extra-contractual referrals than could non-fundholding GPs. The two examples given by respondents working in intensive care areas both related to the necessity to employ age-related criteria for admission to ICU beds in times of bed shortages. For those areas where higher numbers of examples were given in this category a more diverse range of cases were

cited. All gave examples relating to the advantages accorded to the patients of GP fundholders. Respondents working in surgical and trauma/orthopaedic areas also highlighted the drive to reduce the number of patients on waiting lists for over eighteen months, which was seen to disadvantage those who may have had greater clinical need, but had been waiting for a shorter period of time. The apparently high level of examples given in this category by respondents working in medical areas appears to be somewhat different in nature in that quality deteriorations in relation to inequalities here tended to relate to two particular patient groups, older people, and those with chronic illness. This was supported during the interviews.

It's becoming so that we are hesitant to admit someone with a long term illness, because we are likely to experience problems getting them home again, because social services are such a disaster. If services are set up already, and appear to be working reasonably well, it may be that we won't be able to improve things very much, and they could even become worse. Now of course, we will still admit anyone who needs treatment, but in the past we would often admit say a patient with Parkinsons to see if we could better the treatment, and that will require close observation, because things can go wrong. I'm reluctant to do that now, because we might not be able to arrange discharge so easily, and we could end up with a patient in one of our beds for a long time who neither needs nor wants to be there. (Doctor, Medical)

I think that older people get a very bad deal, many of the patients I have would benefit from intensive physiotherapy and occupational therapy, but because these services are limited I feel that they are concentrated on younger patients, not that anyone will admit to that. (Nurse, Medical)

Inequalities have always existed within the NHS, and these have been well recognised and documented. However the evidence of this study suggests that in certain aspects the Reforms have exacerbated some areas of inequalities. This may be a primary effect, such as the unequal advantages enjoyed by the patients of GP fundholders, or a secondary effect, such as the curtailment of services to certain patient groups, as

a way of keeping within financial limits.

Cancellations and delays

37 (28.7%) respondents gave examples of quality deteriorations which came into this category.

Operations are often cancelled on the day.

Emergency operations are often delayed for hours.

Some patients have their operations cancelled two or three times.

There is a much longer wait for some investigations.

Discharges home are often delayed because services can't be set up.

A significant difference did emerge between the hospitals with 26 (35.6%) respondents from Greenfield, compared to 11 (20.8%) from Stockton giving examples of delays and cancellations as a quality deterioration (χ^2 3.211, $p = 0.05$). It is possible that this difference could be a reflection of their different pre-Reform experience.

We have always had to cancel a certain number of our admissions, simply because it is impossible to predict how many of our beds will be required for emergencies. (Nurse, Stockton)

In the past we used to cancel very few of our booked admissions, but now it happens regularly. (Doctor, Greenfield)

A difference which is not statistically significant appears between the professions with 18 (36.7%) doctors and 19 (23.8%) nurses giving examples in this category. This apparent difference is likely to reflect the doctors' greater involvement in attempting

to manage both their waiting lists, and the prioritisation of treatments/investigations within their patient group. Differences appear in relation to clinical speciality, although not statistically significant (Table 9.18).

Table 9.18 Identification of cancellation/delay as a quality deterioration, by clinical speciality

Cancellations/Delays	Number of respondents
Medical	12 (35%)
Surgical	14 (39%)
Trauma/Orthopaedic	6 (40%)
Intensive care	2 (22%)
Theatre/Anaesthetic	2 (15%)
Paediatric	1 (7%)
Other areas	0

The results show that the respondents who have reported the greatest number of quality deteriorations in relation to cancellations/delays are those working within the medical, surgical, and trauma/orthopaedic areas. Those respondents working in theatre/anaesthetic and other clinical areas, whilst often cited by respondents in medical, surgical and trauma/orthopaedic areas as being the originators of such delays, are apparently unaware of this quality deterioration in their own practice. Those respondents working within intensive care and paediatric areas believe that their patients are prioritised, and are aware of the effect of this on other patients.

If our patients need any special investigations as a matter of urgency they do get priority because they are critically ill, but I know that this probably means that a patient somewhere else in the hospital has his or her investigation delayed or even cancelled. (Nurse, Intensive care)

Children are always put first on the operating lists so they are never cancelled because the list has over-run. (Nurse, Paediatrics)

Dealing with patients who are experiencing cancellations and delays is something which causes great concern among both doctors and nurses.

I dread those mornings when we have no empty beds and several patients due to be admitted, and it happens nearly every week . From first thing in the morning we are trying to find ways to empty beds, and it may be that we are able to discharge enough patients or that one of the medical wards can take one of the patients from us, but often we just can't and the patients rings at 10 o'clock only to be told that a bed isn't yet available and they should ring back at twelve, and so it goes on and sometimes the patient may not be admitted until that evening, or even the morning of their operation. Of course the problem then is that we are trying to care for a patient who is both stressed out and inadequately prepared for the operation. Sometimes a patient who has been put on hold will ring the ward directly instead of the bed manager, and some of them are really quite aggressive, and I can understand why, but at the same time I feel like shouting back at them - 'It's not my fault' -what's worse of course is when the patient is very upset, I feel so useless.
(Nurse, Surgical)

If we have a patient who is waiting for an investigation which will determine if they have a life threatening disease, and then we subject them to a delay, which we often do, well I feel that does real harm . (Doctor, Medical)

Premature discharge

Perhaps linked to the previous category is the quality deterioration categorised as premature discharge, of which examples by 21 (16.3%) respondents were given. Premature discharge means the discharge of a patient who in the opinion of the respondent would have been best served by remaining in hospital, as opposed to early discharge, which was not viewed as evidence of quality deterioration

Patients are sent home far too early because we have closed too many beds.

We have gone too far in trying to reduce in-patient length of stay, patients are discharged too early.

Discharging patients too soon.

Patients are sent home when they are still ill and distressed.

There is no difference between the two hospitals in this area of quality deterioration with 12 (16.4%) respondents from Greenfield and 9 (16.1%) from Stockton giving examples in this category. There is a variation between the professions, although not statistically significant, with 16 (20.0%) nurses as compared to 5 (10.2%) doctors providing examples in this category. The doctors who were interviewed recognised that their seniority did, to a degree, protect them from many of the problems associated with premature discharge, and so it is likely that deteriorations in quality here are not so apparent to them.

Of course, in the end, if I need a bed for a desperately ill patient I will put a degree of pressure on the houseman and the nurses to speed up the discharge of a patient, and I know that it causes them problems, but I have to focus on the patient with the greatest need. (Doctor, Stockton)

If we are trying to push for the discharge of an elderly lady who has had a CVA it's the nurses who get all the grief from the relatives and social services, I can to a large degree ignore it, because they won't involve me unless they have to. (Doctor, Greenfield)

Some variation also appears in relation to work areas although this is not statistically significant (Table 9.20).

Table 9.20 Identification of premature discharge as a quality deterioration, by clinical speciality

Premature Discharge	Number of respondents
Medical	7 (21%)
Surgical	9 (25%)
Trauma/Orthopaedic	1 (7%)
Intensive care	2 (22%)
Theatre/Anaesthetic	1 (8%)
Paediatric	1 (7%)
Other areas	0

Respondents working in ‘other’ areas would not normally be directly involved in the discharge of patients. The one example given by a respondent working in theatre/anaesthetics related to the reduced choice of available anaesthetic agents when early discharge is planned, and the one example given by a respondent working in paediatrics related to day care surgery for children. The low level of examples in this area given by respondents working in trauma/orthopaedics is in part because those respondents working within accident and emergency areas would not be directly involved in discharge of other than short stay patients, but why this does not appear to be a problem experienced in the orthopaedic wards cannot be readily explained, and may be no more than chance. Whilst the variation is not statistically significant in medical, surgical and intensive care areas, the quality deterioration associated with premature discharge emerged during the interviews as a common experience, and one which causes much concern.

I think that the level of readmissions due to early discharge is very much underestimated, because when a patient is discharged too early they often feel very dissatisfied, and so if they experience problems they are unlikely to return to the hospital which they feel has treated them poorly. I know that I often see patients in Casualty who have post-operative complications following surgery in another local hospital, and they just will not return to that hospital, and so the people there probably will never include that patient in their audit figures.

In the same way I am sure that some of our patients, if we were to investigate, would have been found to have been readmitted elsewhere because we have sent them home far too early. (Doctor, Surgical)

I really worry about some of the patients I send home, it keeps me awake at nights, because I worry how they will cope. Very often I am put in the position of sending them home in order to be able to admit someone else, when I know that a few more days in hospital would make a great difference to their recovery. (Nurse, Medical)

Comparing the nature of quality changes

In order to include all the examples which were offered by the respondents, and to facilitate comparison between the nature of improvements and deteriorations in the quality of care delivered by respondents in practice, a framework was constructed which incorporated the six principles of quality (Maxwell 1984, Shaw 1986) and the three components of quality (Donabedian 1969). Panel coding was utilised to allocate each example within the framework constructed, and so consider the changes in quality from a range of perspectives.

Of the 184 examples of quality improvement given by respondents it was possible to classify 176, the remaining 8 being too non-specific to classify (Table 9.21). An example of a quality improvement which was classified as a structure/efficiency improvement is that of the development of a centralised admissions service. This speeded up Accident and Emergency and elective admissions by setting up a system to centralise the collation of bed availability data across the hospital, rather than doing this at Unit level. An example of a quality improvement which was classified as a process/access improvement was that of the development of a one-stop breast clinic, which reduced the number of times a woman had to visit the clinic prior to treatment planning. Prior to this development a woman referred with a breast lump would have visited the clinic, been seen by a consultant, then sent away to have a variety of tests done, prior to returning to clinic the following week for results and treatment planning. The setting up of the one-stop clinic revolutionised the process by

arranging for these women to be seen early in the morning, have all their investigations carried out at times designated for patients from this clinic, then returning to see the consultant for diagnosis and treatment planning. This resulted in women waiting less time to be seen in the clinic, and commencing treatment earlier.

It can be seen that clusters of quality improvements appear in the structure column. In relation to the process element, quality improvements here relate most closely to the principles of acceptability and efficiency, and there appear to be very few quality improvements in relation to outcome of care. When considering the principles of quality, there can be seen to be an absence of quality improvements which relate to equity, and very few which relate to appropriateness.

Table 9.21 The nature of quality improvements identified by respondents

	Structure	Process	Outcome
Access	xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxx xx	xxxxxxx	xxx
Equity			
Acceptability	xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxx	
Efficiency	xxxxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxxxx xxxxxx	
Effectiveness	xxxxxxxxxxxxxxxxxx	xx	xx
Appropriateness	xxxxxx		

Of the 424 examples of quality deteriorations given by respondents it was possible to classify 408 (Table 9.22). In relation to these examples, none are identified which relate to outcome, although this was something which emerged marginally during the interviews. Quality deteriorations were identified in relation to both structure and process, although there is a more dense concentration in the process column. Such deteriorations can be noted across the range of principles, with a particularly high concentration in relation to appropriateness. Thus it can be seen that whilst the NHS Reforms have initiated improvements in quality in some areas, these have been counterbalanced by deteriorations in others. Even in relation to those structure aspects of quality which appear dominant in quality improvements, there were also many examples of deterioration in quality.

An example of a quality deterioration which was classified as process/equity was the fast-tracking of fundholding GPs patients at certain times of the year. This process was seen to seriously disadvantage the patients of non-fundholding GPs. An example of a quality deterioration classified as structure/effectiveness was that of discharges home being delayed because home care services were not available.

Despite the adoption of what purported to be a more integrated approach to quality dictated by the Reforms, they do not appear to have had the desired effect of a universal pattern of quality improvement. What is of particular concern is that the focus on structural improvements can, in many cases be argued to have created deteriorations in the process of professional care delivery.

Table 9.22 Examples of quality deteriorations identified by respondents

	Structure	Process	Outcome
Access	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxx	xxxxxxxxxxxxxxxxxx xxxxxx	
Equity	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx x	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx	
Acceptability	xxxxxxxxxxxxxxxxxx xxx	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxx	
Efficiency	xxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxx	
Effectiveness	xxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx	
Appropriateness	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx xxxxxxxxxxxxxxxxxx	

CHAPTER 10

A TYPOLOGY OF PROFESSIONAL RESPONSE TO THE NHS

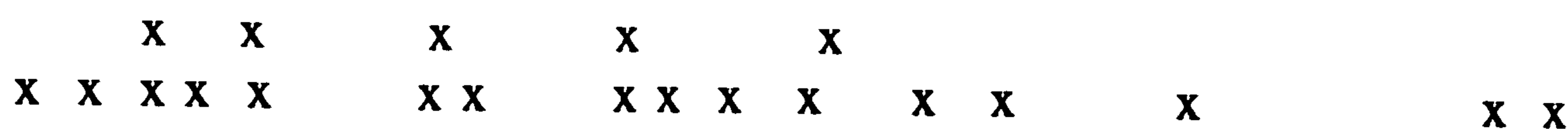
REFORMS

The values and beliefs of professional practice

The principles which underpin the NHS have been clearly stated since Beveridge first presented his vision of a nationalised health service. These principles of equity, comprehensiveness and universality have been widely examined, debated and challenged, yet have remained the bedrock on which the NHS is said to operate for nearly fifty years. What has been less well explored are the principles on which health care professionals practice within the NHS. The principles which guide practice can be seen in the professional guidelines and codes of conduct which set out the framework for professional practice. The values and beliefs on which those principles rest are less explicit as is the question of how these values and beliefs align with the principles which underpin the NHS. It appears to be a taken for granted assumption that the values and beliefs of the health care professionals are congruent with those of the organisation, and what has not been explored is the way in which the two belief systems interrelate and interact.

During the interviews with health care professionals, the values and beliefs of the interviewee were located on the continuum of health care principles outlined by Beauchamp (1976). All respondents were asked to locate their current beliefs, as well as those beliefs of the pre-Reform period, in an attempt to detect any movement along the continuum. When comparing positions a significant degree of clustering has emerged since the implementation of the Reforms (Diagrams 10.0 and 10.1).

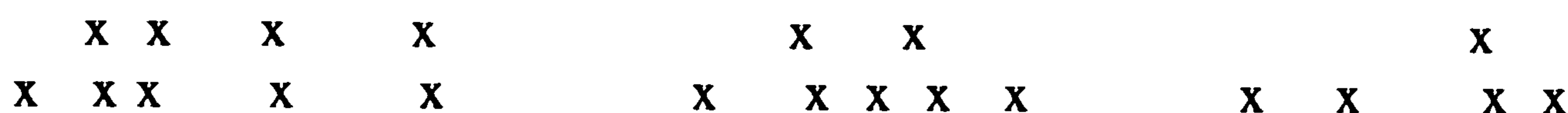
Diagram 10.0 Self location on the continuum of health care beliefs, prior to the NHS Reforms



Health care is a social right which should be funded and provided by the State and freely accessed by all citizens, subject to need.

Health care is a service commodity which should, with limited exceptions, be funded and provided privately, and be subject to the laws of supply and demand.

Diagram 10.1 Self location on the continuum of health care beliefs at time of interview



Health care is a social right which should be funded and provided by the State and freely accessed by all citizens, subject to need.

Health care is a service commodity which should, with limited exceptions, be funded and provided privately, and be subject to the laws of supply and demand.

As can be seen from the above diagrams, there had always been a divergence of values and beliefs in relation to the system of health care among the health care professionals interviewed. The experience of the implementation of the NHS Reforms appears to have consolidated those values and beliefs into three main clusters. When the interviews were analyzed, three distinct types of professional response to the NHS Reforms emerged, which could be seen to align with the self location on the health care belief continuum. At the public justice end of the continuum could be seen the Traditional professional, with egalitarian beliefs, who continued to focus their practice around the needs of the individual patient. At the

market just end of the continuum could be seen the Transformed professional, with managerial beliefs, who focused their practice around the needs of the market. The cluster in the centre of the continuum could be seen to represent the Transitional professional, who shared the some of the beliefs of both the Traditional and the Transformed professional and who attempted to focus their practice on both the needs of the individual and the needs of the market. Each of these three types can be seen to exhibit distinct characteristics in relation to a variety of criteria which emerged from the analysis of the interviews:

- (1) The recognition of the values and beliefs which underpinned their professional practice.
- (2) The initial and on-going response to the NHS Reforms.
- (3) The nature of change in their professional practice.
- (4) The perception of the experience of the implementation of the NHS Reforms.
- (5) The nature of professional relationships with both the patients and the organisation.
- (6) The nature of the focus on quality of care.
- (7) Sources of support and satisfaction from practice.

Each of the three types identified experienced their professional practice in different ways, and could locate the changes that they had experienced in relation to the implementation of the NHS Reforms.

The Traditional professional

Those nine health care professionals who located themselves in the cluster towards

the public justice end of the health care beliefs continuum provided a range of comments during their interviews which indicated that the values and beliefs which underpinned their practice had consolidated and strengthened as a result of their experience of the implementation of the NHS Reforms, and that they were more able to recognise such beliefs as having an important role to play in the shaping of their professional practice:

The more I see of the effects of the introduction of the contracting process, the more I am convinced that it is fundamentally wrong. How can we treat health care as something which is bought and sold when we claim to have a free health care system? In some ways a totally private system would be better, because at least then it's up-front and honest that what you get is what you pay for. The NHS is something we should be proud of. I know we haven't always got it right, but I like to think that we tried to do the best for our patients, and I don't think that we do that now. When I hear my colleagues talking about contracts and costs, quite frankly I'm disgusted. I don't know what's happened to them. They used to be talking about patients and their needs.

I think that the way the NHS has gone is wrong. It values money over people and you'll never convince me that can be right. It makes me sick when I hear politicians talking about good old fashioned values. Where's the good old fashioned values in our hospitals nowadays?

I never used to think much about whether the system was right, I took it for granted that the NHS set out to do the best for people. But now I realise that the system itself has to be sound for sound work to be done in it, and that's what I think we've lost. To me the NHS has changed, and now it's like one of those beautiful looking shiny apples which is full of maggots it might look good on the surface but it's not much use when it's needed.

When I was a student I remember one of our tutors telling us that to maintain

the public's trust in nurses we always had to behave in a way that was ethical and moral, and you know that was probably an off the cuff remark that she made, but it's always stayed in my mind, and that's probably what has made me aware of the ethical difficulties of the new system of contracting. I don't care whether they want to run the NHS like a business or not, but what I do care about is whether or not I, as a nurse, can do my work in a way that is right.

Throughout the interviews with the health care professionals who placed themselves in this category, a recurring theme emerging was a challenging of the justness of the Reforms, and to a large degree, this appeared to be the factor which most influenced a rather negative response to the implementation of the Reforms. Neither did it seem that this response had been markedly modified in the period following the implementation of the Reforms:

I knew that the NHS needed a fairly radical overhaul, after all it was unreasonable to think that it could continue to run unchanged as the world changed around it. But what I objected to was the way in which it was changed. One of the major problems with the NHS was that it had never really had any success in improving the health of those people at the lower end of the social scale, and as far as I can see the NHS Reforms could only worsen the situation.

Most of us working in the NHS could see that the result of making some GPs fundholders would be to make better services available to some patients than to others, and to be honest the only reason that it hasn't been a lot worse than it is, is that I think many of the GPs themselves feel uncomfortable with that. However there are a few who are enjoying their little bit of power, and they don't seem to give a damn that their patients are doing better than patients of non-fundholders.

The ideas which led to the NHS Reforms were wrong then and they're wrong

now, and what I can't understand is why more people are not prepared to stand up and say that. It's almost like brainwashing the way I hear some of my colleagues spouting the views of the managers as if they were some undeniable truth. Tell me, how can it be right for someone with no understanding of the medical facts to decide whether or not I can refer one of my patients to a specialist outside of the area?

I know that there are not enough resources to meet all of the demand but what I object to is the unfair way in which I see those resources shared out. The Reforms have made the NHS a very biased system, with some people doing considerably better than others.

Whilst this group of health care professionals, like all others have experienced changes in the way they have practised, these appear to be less marked than the changes which have been experienced by those located in the other clusters along the health care belief continuum. In fact conscious limitation of changes to practice can be seen to be a feature of this group:

I have not let the changes change the way I view my patients. Like everyone else I have to work harder now than ever before, but I don't put anything before the needs of my patients, and if that means I ignore some of the dictates from management, well that's the way it is. I know that this doesn't make me popular with management. Recently I was told that I had an 'attitude'. Well I only hope that if I ever need to be a patient somebody will have enough of an attitude to care for me before they fill in yet another set of forms!

I try not to get too involved with all the practice management business. I know someone has to do it, but I still see my role as one which is primarily concerned with patient care, and that's where my energy goes.

I'm well aware that I would never be appointed as a ward sister now, but I'm here and it will take a lot to move me. They don't really want sisters who

care for patients any more, they want high flying ward managers, and that's just not my way. To my way of thinking a ward sister should be concerned firstly with the patients, and secondly with the staff, who also need looking after. That's how I see my job, and that's what I do.

Despite the essentially negative response to the NHS Reforms, this group of health care professionals has viewed the experience of the implementation of the NHS Reforms as something which can be seen as both positive and negative. Positive aspects can be seen to relate to structural changes in the system of management, and negative aspects to the stress which has been generated:

I think that the Practice Management Groups have been very successful, and from my point of view it's made it much easier for any concerns I may have, to be heard. Personally, I don't play a very active role in the PMG at the moment. It's not something that I'd rule out completely, but for the time being I'm quite content with the way things are running, and it's made my life easier in many respects.

We have much easier access to management nowadays , and I do think that they are more willing to listen to us, probably more willing than we are to listen to them!

Practice based management groups are proving a much more effective way of running the operational side of our services, and it has allowed more people to become involved. I never thought that I'd become so interested in the running of a unit, but it has meant that the people who carry out the business of the unit have a big say in how it's organised.

Change is always stressful, but I think that the changes that we've been through in the NHS in the last few years have been more stressful than most. Now some of that stress comes from, I know, the fact that we have much more work to do in the same time, but also because we have had to learn the rules

of a whole new way of doing things, and sometimes those rules just don't seem to make any sense whatsoever.

I don't think that many people outside of the NHS will have realised just how much stress has been created by the health service changes. Like many of my colleagues I've been off sick with stress related symptoms, and things don't look likely to improve.

I don't think that there is much compassion around when you talk about stress. I have found things incredibly stressful in recent years, but nothing is really done to help. The way the NHS runs now is bound to cause stress.

In relation to this group's professional relationships within the organizational structure, there is open recognition of differences of opinion, aims and beliefs, yet perhaps somewhat surprisingly, any conflict which is generated is viewed in a positive way, and whilst attempts are made to resolve such conflict, it is not something which the traditional professional seeks to avoid:

The professional staff and the management do see things differently although we are all part of the same organization we have a different perspective on things. Now that's not all together a bad thing because it prevents any of us from becoming too blinkered. So if I get too enthusiastic about some new procedure or gadget I can be sure that the business manager will say - Now hold on, what's the cost implication of this? - and similarly if I feel that he is going too far in attempting to make cost savings, say by freezing nursing vacancies, I will say - We can't do this without some impact on patient care, and that's what we have to consider here.

I feel that I'm very lucky with the managers that I have to deal with, but that's not to say that we don't disagree a lot of the time. To me they are far too concerned with cost rather than care, but I can also see that they see me as being unrealistic in what I expect to be able to achieve. In the past I'm

surprised that we haven't come to blows, and it's been a near thing at times, but I think that we've now got to the stage where we respect each others differences, and although I don't expect it ever to be an easy relationship it is one which enables us to work together, and no matter what it may have been like in the past, we do have to work together as a team.

If a week goes by when I didn't have at least one stand up row with I'd think that something was wrong with either him or me! But I think that's a sign of a healthy relationship. At least we communicate with each other and I think that we have a good understanding of each others point of view, and if I'm honest I think that we prevent each other from any excesses. It's not like it used to be when managers were here to support consultant decisions. Now they're here to challenge them, so of course there is going to be conflict.

Although these Traditional professionals have experienced a change in their relationships with management, the relationships with patients appears to have remained unchanged to any significant degree:

The relationship between doctor and patient is still one which is privileged, and I won't allow anyone else to interfere with that relationship

As a nurse I have always enjoyed a close and special relationship with patients, and that's very important to me, so I've gone out of my way to prevent that changing

At the end of the day, no matter how the NHS might change, the relationship between me and my patient won't, and that's the important thing to keep in mind

Related to this picture of a somewhat intimate relationship which exists between the Traditional professional and patient is the focus which they adopt in relation to the quality of care, which is primarily concerned with the *process* of care, rather than the

structure or outcome:

I think that the money which is being spent on sprucing up the buildings and grounds would be better spent on patient care. After all you never hear a patient telling their relatives how impressed they are with the reception area carpet. What's important to them, and to me, is how well the doctors, nurses and others do their jobs.

Quality of care is all about the way we do things. After all the patient can be admitted to a ward in a way which is caring, concerned and personalised or in a way which is off-hand and routinised. Now in both cases the patient will have been admitted and begun their treatment, but they will perceive the admission very differently

To me quality of care is as much about the little things as the big things. For example yesterday on my ward I saw a student bring an elderly patient in a flower she had picked on her way back from lunch. Now that may seem a very little thing but that patient really felt cared for and important, and to me that is quality of caring.

It is this relationship with patients, and the engagement in the care process which engenders most satisfaction for the traditional professional. They appear to receive support in their work both from the patients and from their professional colleagues, and this support is seen to be an essential component in their professional practice, enabling them to a large degree to be somewhat protected from the negative impacts of the managerialism which is experienced by some of their colleagues:

Despite the stress and the hard work I wouldn't want to do any other kind of work. I know it might sound a bit twee, but when I finish a shift, no matter how bad it might have been, and how glad I might be to go home, I know that the patients will be pleased to see me back the next day, and that does matter to me. In many ways the patients care for us as much as we care for them,

and right, I know that we get our fair share of the moaners and groaners, but most of the patients do appreciate what we are trying to do for them, and they understand if we don't always get it right.....On a bad day it's the patients that keep me going, and it's the patients that make the job worthwhile.

I might come out of a management meeting absolutely seething, but when I get to the wards, things always seem better. There will always be sadness, distress and unhappiness in any hospital, after all people don't come here because things are going well for them, But we all work together, doctors, nurses and patients, to relieve some of this sorrow.....we even manage to find some humour in many situations, and we all help each other through the bad times. Well there must be something good about the work, otherwise so many of us wouldn't carry on doing it would we?

Sometimes it feels as though it's a bit them and us, us being the nurses, doctors and patients, them being the managers!

I get a lot of pleasure from the work that I do, I know this might sound a bit selfish, but I wouldn't be prepared to give up the satisfaction that I get from caring for a patient to the best of my ability.

Good health care is almost totally reliant on good team work, and that's why it is so important for doctors, nurses and the paramedical staff to work closely together, and not allow the managers to divide us in an attempt to get the upper hand.

The Traditional professionals can be seen to have retained, and even strengthened the characteristics within their professional practice which they viewed as important. Although inevitably experiencing a range of effects from the implementation of the NHS Reforms this group appears to have made conscious efforts to control their own practice environment, and demonstrate a confident awareness of their professional role within the NHS.

The Transformed professional

The group of five health care professionals who placed themselves in the cluster towards the market justice end of the health care beliefs continuum appear to have embraced the values and beliefs underpinning the new NHS, demonstrating a strong commitment to the changes, and upholding a belief in the internal market as a force for driving improvement in health care:

It was absolutely essential to exert some degree of control in the NHS, because by the end of the 1980s it was going out of control. I believe that the internal market that has been created does this fairly and at the same time it makes sure that those hospitals which are inefficient or wasteful either change their ways or lose out on their contracts to a point at which they might have to close down.

Because of the system of contracts hospitals have to provide the services which the Health Authority and GPs are willing to pay for, rather than the services they choose to provide. This has meant that we have to constantly improve our services because if we don't and the hospital down the road does, well they will win our contracts, and we will then have to think about cutting back on staff.

We might have had to be dragged into the 1990s screaming and kicking, but now we're here I can see the benefits. People have never really thought about what it was the NHS did, but by introducing the idea of contracts, this has now been closely examined. Like anything else, once money is introduced, then people start thinking about what it is they are getting for their money, and if they can get it cheaper elsewhere, then they will and if one business constantly charges more for the same, than their competitors, then they won't stay in business. It's common sense really, and to be honest I can't see why we haven't done it before, the system's not perfect by any means, but it's considerably better than what we had before.

Before the Reforms we all behaved pretty much as if health care was free, where of course it never has been free, but the way in which it was paid for was sort of hidden. I think that this meant that no-one ever considered what we did in terms of cost, and so there was a lot of waste, and because there was never any talk of care in terms of cost, both we and the patients acted as if there was no limit..... I think that this meant that we didn't value health care because we couldn't easily see the value in terms of money.....Since we changed to the contract system everyone, including the patients have become more aware that someone has to pay for what is wanted, and unless they do, then it can't be provided.....this has meant that we are much more careful in what we do and how we do it, and I think that it's a much more responsible way of going about our business.

The Transformed professionals' initial response to the implementation of the NHS Reforms was positive, albeit guarded in some respects, and their on-going response has become increasingly positive as the effects of the changes become apparent. All the health care professionals interviewed who located themselves in this category had become actively involved in management either at Unit or Board level and viewed this as a positive move:

In the beginning I was worried that because the changes were so great they would prove to be impossible to implement successfully....now we have had our problems, but on the whole I think that it has been very successful, and the more I realise the full potential of the changes, the more I approve of them, it's revolutionized the way I work, and many others as well. I'm all in favour of professional staff becoming more involved in management, and to be quite frank I've no time for those colleagues of mine who are happy to moan and whine about management, but aren't prepared to get off their butts and get involved themselves.

I've always supported the idea of the internal market, although I did have some doubts about the speed with which it was introduced, and I don't think

we had anywhere near enough time to do the sort of thorough preparation that would have made it easier. Some aspects of the Reforms have been more successful than others, the contracting process with the Health Authority needs to be much more streamlined for instance, but I think we've done spectacularly well with our fundholding GPs, and a very healthy relationship has developed there, and I don't think we've yet gone as far as we can in terms of GP contracts - there's a great deal of potential.

I'm a real convert to the benefits of the internal market, it's worked much better than I ever thought it would. Becoming increasingly involved with management has given me a much broader perspective on the way the hospital functions, and I think that it's important for staff at all levels to make the effort to involve themselves in the running of their department.

Whilst the Traditional professional was seen to have consciously restricted change to their professional practice, the Transformed Professional could be seen to have actively sought change, and the nature of this change can be seen to relate to the greater management role which they had taken on.

I spend much more of my time involved in Unit management than I did before the Reforms, because the way the internal market works requires a lot of activity to keep the contracts properly monitored. Of course this does mean that I see less patients than I used to, but in a way that doesn't really matter because the Unit as a whole sees more patients, which is of course a benefit.

I spend much less time on direct patient care than I used to before the Reforms came in, but I have accepted that this is the price that has to be paid if nurses at ward level are going to be able to have a say in how the hospital, or at least their Unit, is managed. Patient care is still the most important thing happening in the hospital, but unless services are properly managed patient care will suffer, and I know that a lot of the other ward sisters complain about the amount of paperwork and meetings they have to keep up with, but the

alternative - to opt out of management completely - is no longer possible, even though people may have got away with it in the past.

I see my professional role differently than I used to, and if professional practice is to survive in the modern NHS, then it has to change to meet the needs of the new system. I'm not talking about giving up responsibilities, although I'm sure that as time goes by some of those responsibilities will naturally devolve to others, but about taking on extra management responsibilities. I think that it's only right that senior medical staff should have a significant say in how services are run, because they are the people with the clearest understanding of those services. I wish that some of my medical colleagues would spend more of their time and energy in trying to allocate resources fairly rather than continually complaining about the lack of resources. I enjoy the management aspects of my work, and I feel it to be a vital part of my professional role.

Not surprisingly, the Transformed professionals have found the experience of the implementation of the NHS Reforms to be positive, and perceive the benefits of the implementation to have far outweighed the disadvantages.

I agree that the speed with which the changes were brought in created some problems, especially in regards to the initial contracts which we negotiated, but the benefits have been impressive, not only for the patients, but also for the staff.....There has been quite a bit of negativity amongst my colleagues about the Reforms, but we had no choice but to make them work, and whilst that has entailed a lot of hard work, we are now reaping the benefits and I'm sure we'll continue to do so. It's been a real challenge, but I've always enjoyed a challenge and whereas when there have been changes in the past I've been very much on the sidelines, this time I've been in the thick of it, and so I've been able to see the whole picture and not just a part of it, and I think that it's been good for me and good for my patients as well.

I'm not saying that the implementation of the Reforms was painless, such a radical change always creates some discomfort at the very least, but it's also created some real opportunities for doctors and nurses to have their voices heard at Board level. I think the main trouble has been the attitude of staff, some of our staff were convinced that the Reforms wouldn't work and were totally negative about the whole thing, and so they have found the implementation of the changes particularly painful. I took a different approach - nothing I said was going to stop the changes coming in and so I had to make sure that I could live with them, and the key to that was understanding what was happening and what was trying to be achieved.....becoming involved in implementing the changes at ward level was very exciting, and I felt that my role expanded enormously during this time.

At the beginning it was difficult to see how we could change so much in such a short time, and although we did experience a number of short term difficulties these were resolved pretty quickly, and all in all everything went surprisingly smoothly, and we began to see benefits for patients very quickly as waiting times fell, and new services were set up.

When considering the Transformed professionals' relationships within the organisation, they can be seen to have aligned themselves with management, and any conflict which they experience has been with other professional groups or individuals:

The key to effective health care services is good management, and that means a good management team, and I feel that here, we have developed a team which works well. We all have different backgrounds, but we respect that, and after all we have a difficult enough job to do without any political infighting. Where I experience most difficulty is in negotiating with my fellow medical staff, because as so often the ones with the least understanding of the situation, are the ones that do the most shouting. I know that some of them feel that I have 'sold out' to management but what they don't realise is that it is not a case of them against us, but us against the threat from other local

hospitals.

Because I am involved in Unit management, some of my colleagues seem to think that I no longer understand the important nursing issues, which is nonsense. Sometimes, I feel that the only people who are making any attempt to work together are the managers, and the rest are just out to fight for their own side, which is a very shortsighted way to go about things.

I feel that we've got a good management team at this hospital, we are clear about what it is that we are trying to achieve, and work together to try and find ways in which we can do what it is that we want to do. I am well aware though, that some of the staff are very antagonistic towards management, which I can't really understand, because after all surely we are all trying to do the same thing - provide the best services that we can for our patients. I really can't see the point of wasting time and energy in fighting each other when the job we have to do is hard enough already.

At the same time that these Transformed professionals can be seen to have strengthened their relationships with management, they can also be seen to have undergone a change in the relationships that they developed with patients, and what appears to have happened is that there has been a move away from the individual relationship that was retained by the Traditional professional, and towards a perception of the central professional/patient relationship as being one which is client group focused rather than being focused on any individual patient.

I have become more and more aware that I can't become too obsessive about what is happening to individuals, but that I need to be more concerned about the service that we offer these patients as a whole. Because after all I might fight - and win - to get a patient an extra-contractual referral authorised, but what I also have to consider is that £10,000 spent on one patient is £10,000 that is not available for anyone else, and we have got to stop acting as if there is no bottom to the NHS purse.

With resources stretched as much as they are, we can't go on pushing for more and more resources to meet the needs of a few patients. We have to make sure that the money is spent where it will give most benefit...a few years ago I didn't appreciate this and if one of my patients needed something I would move heaven and earth to make sure that they got it, whereas now I would feel more comfortable in telling them that what they were asking for is just not available.

I have to consider the needs of all my patients, and I don't feel that I have any right in putting one person's needs above another, and I have to make decisions which may disadvantage one or two patients, but will be beneficial for many more.

This distancing from the individual patient which is a feature of the practice of the Transformed professional is reflected in their focus on the structure element of quality:

One thing the NHS Reforms has done is that it has forced us to look at the way we do things, because now that we are in competition with other hospitals we must be seen to be at least as good as them, if not better. I feel that in the NHS we have been all too ready to talk about health care quality as if it has some mystique, when really it has more to do with the services we provide and the way in which we provide them, than with any airy-fairy notions of the sanctity of the doctor-patient relationship. OK, I realise that patients need to be greeted by name, given enough information, given a chance to ask questions and all that, but in the end it will have benefitted more patients that we have reduced waiting times than if we send Consultant X on an expensive course so that he talks to people in a way which is more 'politically acceptable'.

I know that the money which has been spent on upgrading certain areas of the hospital has been criticised by some people, but I happen to agree that the

surroundings do matter, they give a certain message to people, after all if a patient comes to an out-patients department which is in need of a coat of paint, and littered with out of date magazines and notices, then I think that they must doubt whether that department can be relied on to give them the best sort of care

In trying to improve the quality of our services it has been very important to examine the structure as well as the organisation, and in some cases we realised that we were trying to provide services in a way which actually prevented us being able to achieve any real quality, and those things have been changed, and quality has improved

The Transformed professionals, in constructing their new way of practice, obtain support for, and satisfaction from their professional practice from their management role and management colleagues, rather than from patients or professional colleagues:

I find my management role taking up more of my time recently, and although I am relatively new to management, I have found the business manager and others very supportive, I feel that I can talk to them about any difficulties we are experiencing in the Unit, and although there is not always a clear solution, it helps that others appreciate my point of view, and can understand the situation in which I have to work

I get a lot of satisfaction from being able to see something through from beginning to end, which to be honest is something that is missing in patient care, with the rapid throughput of patients we have nowadays. But when a new project comes up I can be pretty much sure that I will be encouraged to see it through, not that help is not available, but that project will be my responsibility until it is complete.

Although I have not found it easy I do feel a sense of achievement when my budget balances at the end of the month, and I feel even better if I have

managed to make some savings, and in a way I feel that achievements like this are more readily recognised than what I may have achieved in terms of patient care - I've certainly had more positive feedback.

The Transformed professionals have developed a very different framework for their professional practice than the Traditional professional, rather than seeking to retain the characteristics of traditional professional practice, this group of health care professionals actively sought to change the nature of their practice and are, in the main satisfied with their new professional roles.

The Transitional Professional

The seven health care professionals who located themselves in the central cluster on the health care belief continuum share characteristics of both the Traditional and Transformed professional, but the impact of this duality seems to have created some distress amongst this group. Whilst they may indeed prove to be truly transitional, and undergoing further change which will locate them within one of the other two groups, there is some evidence to suggest that the experience of this group may predispose them to give up professional practice rather than undergo further change. What is clearly evident is that the health care professional within this group can both identify that they hold values which fall at either end of the continuum, and also recognise that these values are conflicting:

I suppose that I must fall somewhere in the middle, it's difficult really because whilst I believe in the ideals of the NHS, I find it very difficult to see how we can attempt to meet those ideals, when there just can't be enough money to go round.....although I would argue with anyone that our system of free health care is the best in the world, and that people should be entitled to free health care, but I also believe that there has to be a limit to the care that can be provided, and that perhaps by bringing in the financial element, well that may be the only way limits can be imposed.

Although I strongly support the idea of free health care to those in need, I

don't approve of wasting our health care resources, and so there should be some things that fall outside of the remit of the NHS...IVF for instance. Whilst I feel very sympathetically towards infertile couples, I don't think that just because we can do something about it in some cases that we always should, and I don't see why the taxpayer should fund treatment for any sort of cosmetic surgery. Of course the problem is that there will never be any agreement on where the NHS should draw the line, and this is sure to cause problems, and in a way I feel that my support for free health care should be free from any exceptions, because when exceptions are made then the system must be weakened.

I've certainly moved more towards the middle in recent years as I've become more aware of the impossibility of any attempt to meet all of the demand for health care. But at the same time I find it very difficult to reconcile my belief in the NHS with my acceptance of the internal market as a system for controlling expenditure on health care.

The Transitional professionals exhibited a mixed response to the NHS Reforms, supporting some aspects, but opposed to others:

I think that the idea of the contracting arrangements for health care is a good thing, because it has made many people stop and think what they are doing because they now have to compete with others, and this has forced them to work on improving their services. What I don't agree with is the idea of GP fundholding, and I don't think that some of the local GPs are handling it very well at all, they are attempting to play one hospital off against another, and are threatening to move their patients from hospital to hospital. When I consider the amount of time that is spent trying to dance to the tune of these GPs I just can't see that it's a useful exercise.

I think that GP fundholding is an important way of strengthening primary care, and I believe that it has gone some way towards equalising the

relationship between GP and hospital consultant. What I cannot see the point of is the never ending round of contract negotiations with the Health Authority, it's a waste of time, and I don't see that it has been anything other than an extension of the management relationship they used to have with hospitals, another tool which they can use to attempt to control us.

I haven't got any problems with the idea of an internal market, but what I can't tolerate is the bureaucracy that has been created, surely there must have been a way that the internal market could have been introduced without all this.

The NHS needed to become more business like and in that respect the Reforms have been very successful, but like any business it has become more cut-throat, and I think that those of us working in the NHS just weren't prepared for that.

The Transitional professional can be seen to have retained their pre-Reform roles as well as taking on an increased management role, but unlike the Transformed professional who underwent a role transformation, this can be seen more in terms of a role expansion, which has had negative effects in terms of the stress which has been generated :

I often feel like I am trying to do two jobs, a ward sister and a manager, which to my mind are two separate jobs, even though I am always being told that being a ward manager includes both clinical and management duties. But what it is really is that I am given more and more to do all the time with nobody ever taking on any of my work. I have this vision of an unseen manager somewhere up in the Board Offices who won't be truly content until all of his work has been off-loaded to some other poor devil like me!

I just can't be all things to all people, no matter what they expect of me, and it's totally unreasonable to expect me, or any of my colleagues, to be able to work under the sort of stress that we are being put under by the sheer volume

of our workload. I sometimes long for the days when I was simply concerned with patient care, and I didn't have to take on all of the management that I am now expected to do.

I don't have the time to do any aspect of my job properly, because there is just too much to do. If I concentrate on the clinical aspects of my work, then I neglect the management, and if I attempt to do all of the management that I am expected to do, then there just isn't enough time to devote to patients, and it's not only incredibly stressful but also demoralising, as I go home every day feeling that I haven't done anything to the best of my ability.

How the Transitional professional has perceived the experience of the implementations of the Reforms, has been far more negative than their Traditional or Transformed colleagues, and there is evidence to suggest that there exists real distress amongst the health care professionals in this group, a significant number of whom were planning to leave the NHS or were at least considering such a move:

I don't think that I'm exaggerating if I say that the last few years have been pure hell for me, I used to love my work but not any longer, in fact I am going to be taking early retirement shortly, because I really don't see a place for myself in the hospital any longer. I always imagined that I'd die in harness so to speak, and retirement was never something that I looked forward to, but now I can't wait to go.....It saddens me the way that doctors and nurses are expected to practice nowadays, there is just no space for them to develop and perfect their skills, it's all rushing to meet deadlines and coping with crisis after crisis. I'm lucky I have the option to retire, I really don't know how some of my younger colleagues can face spending another 20 years in practice.

Perhaps it's just that I don't cope well with pressure, but it's getting to the point when I don't know how much longer I can carry on. Every day brings more problems and more work, and I can never seem to get through all I need

to do in a day, no matter how late I work, and no matter how hard I work there is always someone complaining that there is something I haven't done, whether its the bed manager complaining that I haven't cleared beds quickly enough or a patient complaining that I haven't made her out-patient appointment yet.

In the years since the Reforms came in work has become more and more unbearable, there is such pressure on us to meet this target or that deadline, and if I worked 24 hours a day I just couldn't get through the amount of work that there is to be done, and now they are talking about rationalising my staff levels, which I know means a certain reduction, not an increase. Well if they do they can do it without me because I just can't go on, and that would be the straw that breaks my back.

I think the time has come for me to consider another area of practice, and as much as I'd hate to give up hospital practice I don't think that I could face another 15 or 20 years working under this sort of pressure, and maybe my only way out would be to go into private practice, or perhaps go abroad to work. I don't think that it's only me that has found these changes so hard to stomach, when I look around me I see many of my colleagues struggling to survive in this so-called caring service - it's a joke really, or would be if it wasn't so tragic.

It is amongst the group of Transitional professionals that relationships within the organisation seem to have become most fragmented:

I am sure that the managers just see the nursing staff as a necessary evil. They might pay lip service to including us in the management process, but I don't see that we have developed an effective working relationship. To be honest I don't even think that as a group of senior nurses we work well together any longer, everyone seems to have retreated into their shell as they try and keep their own head above water.

I don't really know how I see myself any longer, as a clinician or as a manager, and to be honest I no longer fit into either camp with any degree of comfort.

I am actively involved in Unit management, but this has its drawbacks in terms of working relationships. The managers see me as representing the interests of the medical staff and the medical staff see me as representing the interests of the Management Board, whereas of course we should all be here to represent the interests of the patients shouldn't we? But what this means is that many of my working relationships have become rather strained.

When considering the relationships that the Transitional professional has with patients, again this group can be seen to fall between the Traditional and the Transformed professional. The Transitional professional perceives the relationship as being both with the individual and the client group as a whole, which generates some degree of conflict within their day to day practice:

I feel that I am able to enjoy good relationships with my patients, but there is often a dilemma in trying to meet the needs of individuals, and at the same time trying to do the best that I can for the service as a whole. For example if, at the beginning of the financial year we use resources too liberally in order to meet the needs of all the individuals in our care, then we will have run short of resources at the end of the year, so patients then might not be able to have all they need, but who am I to deny patients what they need because someone else may need it later on in the year?

Although I deplore having to discharge patients before I feel that they are really ready to go home, I sometimes have to do this in order to make room for the patients who need to be admitted for treatment, and it's very often difficult to reconcile the needs of the patients we are caring for with the needs of those who are waiting to access that care.

I hate having to put limits on what we can provide for some of our patients, but unless I do we'd run out of money well before we run out of year, and then no-one would get anything. I think that the most I can do is to be honest with the patients about what it is that we can do, and generally they do understand. We tend to have more arguments from the relatives, who understandably want the best for their nearest and dearest.

The attempts of the Transitional professional to relate to both the individual and the client group has resulted in a greater focus on the outcomes of care as a quality measure, although the quality of the process of care is also important for this group of health care professionals:

I know that the way we do things is important, but I think that the real test of quality can only be seen in our results, and I don't know that we actually get enough information about the longer term outcomes of our service, because patients are sent home much quicker, and are more likely to be followed up by their GP than they used to be.

I think that we need to find better ways of finding out about how successful our care has been, we don't always find out for instance if a patient that we have discharged has been readmitted to another hospital, unless that hospital or the GP lets us know, which they often don't.

I think that there is still a great deal of waste in the NHS, and I think that they spend far too much money on prettying up the hospital, which in the end doesn't make a blind bit of difference in how quickly or how well a patient recovers, and to my way of thinking this is where we should be trying to improve things.

This group of health care professionals was the only one not to identify clearly any source of support for their professional practice, and in some cases explicitly stated that they felt they were unsupported, although they did appear to derive some degree

of job satisfaction from their interaction with patients:

Since the Reforms I feel that I've become more and more isolated, everything is done so differently it's as if we were trying to play a game without really knowing the rules, there's no form of staff support any more and I don't feel that I can go to the Director of Nursing with any problems I have, at least not in the same way that I used to be able to go to the nurse manager of our Unit, I just muddle along as best as I can in some circumstances.

Although I do still get a lot of pleasure from my work with patients, I think that a lot of the old camaraderie of the hospital has been lost. We used to be prepared to work late or come in on our days off because we did really feel part of a team, but now I think we do those sort of things more because we fear that we might lose our job if we didn't.

If it wasn't for the fact that I still enjoy my work with patients, I wouldn't still be here, because today's NHS is not a pleasant place to work. I get the feeling that they are prepared to work us into the ground, because there will always be someone else able to take our place. No-one really cares about the staff any more, we're expected to keep our heads down, get the work done and not cause any problems for the managers, and if we should have a problem - well forget it because no-one's interested or willing to help.

This group of Transitional professionals can be seen to have responded in a different way to the implementation of the NHS Reforms than did their Traditional or Transformed colleagues, and the mixed values and beliefs that they hold, have prevented them from being able to construct their professional practice in a way which is both meaningful and manageable.

CHAPTER 11

PROFESSIONAL PRACTICE IN THE NEW NHS. A CONSIDERATION OF THE FINDINGS

Major findings of the study

A number of significant features of the impact of the NHS Reforms on professional practice were revealed during the study:

- (1) 97% of doctors and nurses studied had experienced an increased workload.
- (2) The increase in workload had been greater in relation to indirect care and administration than in relation to direct care.
- (3) 91% of doctors and nurses had experienced increased levels of stress.
- (4) 80% of doctors and nurses had experienced an increased degree of conflict with hospital management.

There had also been several notable changes in the way in which the nature of professional practice had changed for these doctors and nurses:

- (1) Over half of the doctors and nurses responding to the survey claimed that they were involved in a greatly increased bureaucracy.
- (2) Just under half of the doctors and nurses surveyed were spending less time with individual patients.
- (3) Almost four in ten doctors and nurses felt that they did not have adequate support, and three in ten were having to work longer hours.

When considering the quality of care which doctors and nurses felt that they offered to their patients:

- (1) Six in every ten believed the quality of care they gave to patients had worsened or failed to improve.
- (2) Only 41 % of respondents offered examples of improvements in quality of care. 71 % offered examples of deteriorations in the quality of care.
- (4) Over twice as many examples of deteriorations in quality were offered than were examples of improved quality.
- (5) Where deteriorations in quality were evident, these were experienced by a greater number of respondents than were improvements in quality
- (6) All six key principles of quality (Maxwell 1984, Shaw 1986) were seen to be threatened, but under greatest threat were the principles of equity and appropriateness.

These findings must call into question the ability of the Reforms to deliver what was initially promised, and also the ability of the NHS to survive into the next century. Crucial to appraisal of the implementation of the Reforms must be an appreciation of the unintended consequences of the policy relating to the structure and function of the internal market. Although a small scale study into a large scale institution, the importance of the unintended consequences in relation to the professional practice of doctors and nurses has been demonstrated, and the interface between the health care professional and the organisation is an area which must be adequately addressed prior to any further major reorganisation or change in policy direction.

Professional practice in the new NHS

No matter how the health care system is structured, the way it functions will remain reliant on the effectiveness of the health care professional working within it. When

considering the typology of professional response to the NHS Reforms it can be seen that there are several issues which need to be appraised. The Traditional professional, whilst not sharing the values of the internal market system, and in fact opposing them, has nevertheless been able to retain a strong professional role within the health care system. It could be argued that this group of professionals has a particular role in identifying and preventing the potential excesses of the NHS Reforms, in acting as a brake to the more radical changes. Whilst they have experienced some negative effects from the policy implementation, they have to a degree cushioned the impact on everyday professional practice by their insistence on retaining their traditional professional role.

The Transformed professionals, in sharing the values of the new health care system, have been able to restructure their professional roles in a way which reflects those values, integrating their professional and management roles fully. They have developed new supportive relationships with their non-clinical management colleagues, which has accorded them some degree of protection from the conflict with their professional colleagues that their transformed role may have generated. In relocating the focus of their relationship with patients from the individual to the group, the Transformed professional has been able to perceive the benefits of the Reforms more readily, and has avoided the area of potential conflict between their management and their professional role that may have been more apparent had the focus of their relationship with patients remained at the individual level.

The Transitional professionals are the group which has been most adversely affected by the implementation of the NHS Reforms, and the conflict which exists in the health care values that they hold is reflected in the conflict that they experience in their everyday professional practice. This area of conflict has been exacerbated as they try to meet the often incompatible needs of both the organisation and the individual patient, and it is this which has resulted in their negative experience of the Reforms. The negativity of their experience has been aggravated by the lack of support from colleagues, and is only partially mitigated by the satisfaction that they obtain from their interactions with patients. What must be a matter of concern is

that, to some in this group, the situation is viewed as irresolvable, so the only viable option is to leave the NHS. The existence of this disenfranchised group is an obviously unintended consequence of health policy implementation, but one which may prove to have very harmful long term effects on the health care system as a whole. The education of health care professionals is expensive, the acquisition of experience to function at an expert level takes years of clinical practice, and so it is essential to ensure that such valuable human resources are retained and encouraged to fulfil their potential within the system which has enabled their expertise to develop.

Final considerations

One question which needs to be asked is how typical are the hospitals in this study? If they are typical then what might be the effect on both the knowledge base of the health care professions, and the ability to deliver health care services if there is a decline in the number of experienced professional staff? Is it possible that the findings relating to doctors and nurses would be consistent for other professional groups? The shortage of appropriately qualified health care staff already presents problems in some areas, so is this situation likely to worsen?

If, as this study would appear to suggest, the new NHS is an environment in which a significant number of health care professionals are unable to practice as effectively as they should, what needs to be changed? Is it the health care professional, or the system within which they engage in clinical practice?

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APPENDIX 1

Changes in workload relating to clinical speciality

Workload	Medical areas
Greatly increased	21 (62%)
Increased	12 (35%)
Unchanged	1 (3%)
Decreased	0
Greatly decreased	0

Workload	Surgical areas
Greatly increased	24 (67%)
Increased	10 (28%)
Unchanged	1 (3%)
Decreased	0
Greatly decreased	1 (3%)

Workload	Trauma/Orthopaedic areas
Greatly increased	8 (53%)
Increased	7 (47%)
Unchanged	0
Decreased	0
Greatly decreased	0

Workload	Intensive care
Greatly increased	3 (33%)
Increased	6 (67%)
Unchanged	0
Decreased	0
Greatly decreased	0

Workload	Theatre/Anaesthetics
Greatlly increased	4 (31%)
Increased	9 (69%)
Unchanged	0
Decreased	0
Greatly decreased	0

Workload	Paediatric areas
Greatly increased	3 (20%)
Increased	11 (73%)
Unchanged	1 (7%)
Decreased	0
Greatly decreased	0

Workload	Other clinical areas
Greatly increased	2 (33%)
Increased	4 (67%)
Unchanged	0
Decreased	0
Greatly decreased	0

APPENDIX 2

Changes to level of direct care carried out by clinical speciality

Direct care	Medical areas
Greatly increased	7 (21%)
Increased	14 (41%)
Unchanged	11 (32%)
Decreased	1 (3%)
Greatly decreased	1 (3%)

Direct care	Surgical areas
Greatly increased	6 (17%)
Increased	13 (36%)
Unchanged	7 (19%)
Decreased	8 (22%)
Greatly decreased	2 (6%)

Direct care	Trauma/Orthopaedic areas
Greatly increased	2 (13%)
Increased	6 (40%)
Unchanged	5 (33%)
Decreased	2 (13%)
Greatly decreased	0

Direct care	Intensive care
Greatly increased	0
Increased	3 (33%)
Unchanged	5 (56%)
Decreased	1 (11%)
Greatly decreased	0

Direct care	Theatre/Anaesthetics
Greatly increased	1 (8%)
Increased	5 (39%)
Unchanged	2 (15%)
Decreased	5 (39%)
Greatly decreased	0

Direct care	Paediatric areas
Greatly increased	0
Increased	5 (33%)
Unchanged	6 (40%)
Decreased	4 (27%)
Greatly decreased	0

Direct care	Other clinical areas
Greatly increased	0
Increased	3 (50%)
Unchanged	0
Greatly decreased	2 (33%)
Decreased	1 (17%)

APPENDIX 3

Changes in level of indirect care carried out by clinical speciality

Indirect care	Medical areas
Greatly increased	17 (50%)
Increased	11 (32%)
Unchanged	6 (18)
Decreased	0
Greatly decreased	0

Indirect care	Surgical areas
Greatly increased	14 (39%)
Increased	14 (39%)
Unchanged	7 (19%)
decreased	1 (3%)
Greatly decreased	0

Indirect care	Trauma/Orthopaedic
Greatly increased	6 (40%)
Increased	9 (60%)
Unchanged	0
Decreased	0
Greatly decreased	0

Indirect care	Intensive care
Greatly increased	1 (11%)
Increased	3 (33%)
Unchanged	5 (56%)
Decreased	0
Greatly decreased	0

Indirect care	Theatre/Anaesthetic
Greatly increased	6 (46%)
Increased	6 (46%)
Unchanged	1 (8%)
Decreased	0
Greatly decreased	0

Indirect care	Paediatric areas
Greatly increased	0
Increased	11 (73%)
Unchanged	4 (27%)
Decreased	0
Greatly decreased	0

Indirect Care	Other clinical areas
Greatly increased	1 (17%)
Increased	3 (50%)
Unchanged	2 (33%)
Decreased	0
Greatly decreased	0

APPENDIX 4

Changes to level of administration carried out by clinical speciality

Administration	Medical areas
Greatly increased	18 (53%)
Increased	11 (32%)
Unchanged	5 (15%)
Decreased	0
Greatly decreased	0

Administration	Surgical areas
Greatly increased	22 (61%)
Increased	13 (36%)
Unchanged	1 (3%)
Decreased	0
Greatly decreased	0

Administration	Trauma/Orthopaedic
Greatly increased	12 (80%)
Increased	3 (20%)
Unchanged	0
Decreased	0
Greatly decreased	0

Administration	Intensive care
Greatly increased	6 (67%)
Increased	3 (33%)
Unchanged	0
Decreased	0
Greatly decreased	0

Administration	Theatre/Anaesthetic
Greatly increased	5 (39%)
Increased	7 (54%)
Unchanged	1 (8%)
Decreased	0
Greatly decreased	0

Administration	Paediatric
Greatly increased	5 (33%)
Increased	9 (60%)
Unchanged	1 (7%)
Decreased	0
Greatly decreased	0

Administration	Other clinical areas
Greatly increased	2 (33%)
Increased	4 (67%)
Unchanged	0
Decreased	0
Greatly decreased	0

APPENDIX 5

Changes to level of conflict with managers by clinical speciality

Conflict with managers	Medical areas
Greatly increased	13 (39%)
Increased	15 (46%)
Unchanged	4 (12%)
Decreased	0
Greatly decreased	2 (6%)

Conflict with managers	Surgical areas
Greatly increased	14 (39%)
Increased	13 (36%)
Unchanged	8 (22%)
Decreased	1 (3%)
Greatly decreased	0

Conflict with managers	Trauma/Orthopaedic
Greatly increased	6 (43%)
Increased	7 (50%)
Unchanged	1 (7%)
Decreased	0
Greatly decreased	0

Conflict with managers	Intensive care
Greatly increased	4 (44 %)
Increased	4 (44 %)
Unchanged	1 (11 %)
Decreased	0
Greatly decreased	0

Conflict with managers	Theatre/Anaesthetic
Greatly increased	5 (42 %)
Increased	6 (50 %)
Unchanged	1 (8 %)
Decreased	0
Greatly decreased	0

Conflict with managers	Paediatric areas
Greatly increased	4 (27 %)
Increased	8 (53 %)
Unchanged	2 (13 %)
Decreased	1 (7 %)
Greatly decreased	0

Conflict with managers	Other clinical areas
Greatly increased	2 (33 %)
Increased	2 (33 %)
Unchanged	2 (33 %)
Decreased	0
Greatly decreased	0

APPENDIX 6

Changes to the level of stress experienced by clinical speciality

Stress	Medical areas
Greatly increased	19 (56%)
Increased	12 (35%)
Unchanged	3 (9%)
Decreased	0
Greatly decreased	0

Stress	Surgical areas
Greatly increased	23 (64%)
Increased	10 (28%)
Unchanged	3 (8%)
Decreased	0
Greatly decreased	0

Stress	Trauma/Orthopaedic
Greatly increased	9 (60%)
Increased	5 (33%)
Unchanged	1 (7%)
Decreased	0
Greatly decreased	0

Stress	Intensive care
Greatly increased	5 (56%)
Increased	4 (44%)
Unchanged	0
Decreased	0
Greatly decreased	0

Stress	Theatre/Anaesthetic
Greatly increased	7 (54%)
Increased	6 (46%)
Unchanged	0
Decreased	0
Greatly decreased	0

Stress	Paediatric areas
Greatly increased	6 (40%)
Increased	5 (33%)
Unchanged	3 (20%)
Decreased	1 (7%)
Greatly decreased	0

Stress	Other clinical areas
Greatly increased	1 (17%)
Increased	5 (83%)
unchanged	0
Decreased	0
Greatly decreased	0

APPENDIX 7

Changes to quality of care offered, by clinical speciality

Quality of care	Medical area
Improved due to Reforms	7 (23%)
Improved unrelated to Reforms	9 (29%)
Unchanged	4 (13%)
Worsened due to Reforms	9 (29%)
Worsened unrelated to Reforms	2 (7%)

Quality of care	Surgical area
Improved due to Reforms	3 (9%)
Improved unrelated to Reforms	3 (9%)
Unchanged	9 (27%)
Worsened due to Reforms	17 (50%)
Worsened unrelated to Reforms	2 (6%)

Quality of care	Trauma/Orthopaedic
Improved due to Reforms	3 (23%)
Improved unrelated to Reforms	1 (8%)
Unchanged	3 (23%)
Worsened due to Reforms	5 (39%)
Worsened unrelated to Reforms	1 (8%)

Quality of care	Intensive care
Improved due to Reforms	2 (25%)
Improved unrelated to Reforms	0
Unchanged	4 (50%)
Worsened due to Reforms	2 (25%)
Worsened unrelated to Reforms	0

Quality of care	Theatre/Anaesthetics
Improved due to Reforms	3 (23%)
Improved unrelated to Reforms	2 (15%)
Unchanged	0
Worsened due to Reforms	7 (54%)
Worsened unrelated to Reforms	0

Quality of care	Paediatric
Improved due to Reforms	4 (31%)
Improved unrelated to Reforms	1 (8%)
Unchanged	5 (39%)
Worsened due to Reforms	3 (23%)
Worsened unrelated to Reforms	0

Quality of care	Other clinical areas
Improved due to Reforms	1 (20%)
Improved unrelated to Reforms	1 (20%)
Unchanged	2 (40%)
Worsened due to Reforms	1 (20%)
Worsened unrelated to Reforms	0

APPENDIX 8

THE NHS REFORMS AND PROFESSIONAL PRACTICE

This survey is part of a study to explore the way in which the professional practice of doctors and nurses has been changed by the NHS Reforms of 1991. I would be very grateful if you could take the time to complete this questionnaire and return it in the enclosed envelope.

All information will remain confidential, and will not be used for any purpose other than the study referred to above.

If you have any queries or require further information please do not hesitate to contact Kay Caldwell on Tel: 0123 456 7890

Please tick the appropriate box to indicate your answer

(1)	Where do you work?	Greenfield	<input type="checkbox"/>
		Stockton	<input type="checkbox"/>
(2)	What is your profession?	Medicine	<input type="checkbox"/>
		Nursing	<input type="checkbox"/>
(3)	What is your gender?	Male	<input type="checkbox"/>
		Female	<input type="checkbox"/>
(4)	How old are you?	Under 25	<input type="checkbox"/>
		26-35	<input type="checkbox"/>
		36-45	<input type="checkbox"/>
		46-55	<input type="checkbox"/>
		56 or over	<input type="checkbox"/>

(5)

How long have you worked in the NHS?

Under 5 years

5-9 years

10-14 years

15+ years

☐

☐

☐

☐

(6)

How long have you worked in your present post?

Under 5 years

5-9 years

10-14 years

15+ years

☐

☐

☐

☐

(7)

In which clinical speciality do you work?

Medical speciality

Surgical speciality

Trauma/Orthopaedics

Intensive Care

Theatre/Anaesthetic

Paediatrics

Other

Please specify

☐

☐

☐

☐

☐

☐

☐

(8) What effect have the NHS Reforms had on your workload?

- Greatly increased ☐
- Increased ☐
- Unchanged ☐
- Decreased ☐
- Greatly decreased ☐

(9) If your workload has changed in what area has this occurred?

(a) Direct care that is patient oriented and carried out in direct contact with the patient.

- Greatly increased ☐
- Increased ☐
- Unchanged ☐
- Decreased ☐
- Greatly decreased ☐

(b) Indirect care that is patient oriented but not carried out in direct contact with the patient e.g. liaising with others on behalf of the patient.

- Greatly increased ☐
- Increased ☐
- Unchanged ☐
- Decreased ☐
- Greatly decreased ☐

- (c) Administrative work that is not oriented to an individual patient e.g. budget control.

Greatly increased ☐

Increased ☐

Unchanged ☐

Decreased ☐

Greatly decreased ☐

- (10) Has the level of stress generated by your work changed as a result of the reforms?

Greatly increased ☐

Increased ☐

Unchanged ☐

Decreased ☐

Greatly decreased ☐

- (11) Has there been any change in the degree of conflict you experience with your managers as a result of the Reforms?

Greatly increased ☐

Increased ☐

Unchanged ☐

Decreased ☐

Greatly decreased ☐

- (12) Has your practice changed since as a result of the Reforms? Please give examples.
- (13) Please give examples of any improvements in the quality of care as a result of the Reforms.
- (14) Please give examples of any deteriorations in the quality of care as a result of the Reforms.
- (15) In terms of the effects of the NHS Reforms on the care you give to your patients, which applies to you?
- | | |
|--|--------------------------|
| Care improved due to the Reforms | <input type="checkbox"/> |
| Care improved unrelated to the Reforms | <input type="checkbox"/> |
| Care remains unchanged | <input type="checkbox"/> |
| Care worsened unrelated to the Reforms | <input type="checkbox"/> |
| Care worsened due to the reforms | <input type="checkbox"/> |

Thank you very much for taking the time to complete this questionnaire